spermatocytes. After three years with a gluten-free diet seminal analysis in 1958 showed a sperm count of $45 \times 10^6/\text{ml}$ with 90% active progressive motility and normal morphology, and a second testicular biopsy, apart from slight capsular thickening, was essentially normal. He married in 1960 and his wife gave birth to a normal male child.—I am, etc.,

GEORGE FOSS

Bristol

1 Foss, G. L., *British Medical Journal*, 1962, 2, 368.

Relative Cost of Drugs

SIR,—As the cost of the N.H.S. soars attention is, rightly, being paid to reduction in expenditure wherever possible. The Department of Health and Social Security's contribution to cost-consciousness in prescribing is the circulation of bar graphs showing, with immediate visual impact, the relative costs of different medicaments in a therapeutic group. While the small print makes disclaimers the result of this visual approach is to suggest that the drugs mentioned are of equal dose and benefit. The absurdity of these comparisons has reached its apogee in the recent handout "Drugs used in Rheumatic Diseases." The cost of 100 tablets of each of six preparations—soluble aspirin B.P., Brufen, Indocid, Fenopron, Orudis, and Naprosyn—was compared. The only logical comparison is of the usual recommended starting dose of each preparation, the dose of aspirin being the minimal anti-inflammatory dose (12 tablets). Such a comparison yields both a difference in order of cost and a narrowing of the gap between different preparations (table I).

TABLE I—Comparison of Costs of Different Medicines in a Therapeutic Group in Relation to their Dose

Preparation	Cost/100 Tablets (£)	Starting Dose/Day	Days/100 Tablets	Cost/Day (p)
Soluble aspirin B.P.	0.24	12	8½	2.9
Brufen	2.06	6	16½	12.4
Indocid	2.54	3	33½	7.6
Fenopron	3.09	3	33½	9.3
Orudis	5.31	3	33½	15.9
Naprosyn	7.70	2	50	15.4

TABLE II—Preference of 200 Patients and 72 General Practitioners for Dose Frequency of Drugs

	Mean Preference Scores (%) for:			
	Once Daily	Twice Daily	Thrice Daily	Four Times Daily
Patients	73	67	56	38
Doctors	74	70	49	31

Publicity of this kind is counter-productive for two reasons. Firstly, those with a knowledge of the comparative doses of these drugs will immediately dismiss this pamphlet, and by association all others from the same source, as misleading nonsense. More tragically, this approach militates against preparations which require reduced tablet intake and less frequent dosage. In a survey which we have recently completed patients and general practitioners were asked to score the various features of anti-rheumatic therapy. Both groups showed a significant preference for reduced dosage frequency (table II). Departmental denigra-

tion of these desirable features might prejudice further attempts to ease the burden of medication in patients with long-standing disease. At best this shows a lack of appreciation of the problems; at worst a heartless contempt for the patients' needs.

Finally, a pharmaceutical company claiming a cost benefit for its product by comparing the price of eight days' treatment with 50 days' of a competitor would be considered unethical. Why should the D.H.S.S. adhere to any lesser ethical standard?—We are, etc.,

Middlesbrough General Hospital,
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IAN HASLOCK

V. WRIGHT

Late Recurrence of Thrombotic Thrombocytopenic Purpura

SIR,—In their report on "Late Recurrence of Thrombotic Thrombocytopenic Purpura after Splenectomy" Dr. D. J. Howard and his colleagues (10 May, p. 317) use the term "unique" in referring to their case and also state that "late recurrence of T.T.P. has not been described."

A case was seen by me in 1956, and subsequently published,¹ of several relapses and recurrences over a period of 18 years before the final fatal episode. Histological proof of the existence of the characteristic lesion was found in a breast biopsy performed three years before death. This publication included a résumé of cases reported in the literature to date in which late recurrences had been described. One of them² was of a patient whose condition recurred two years after splenectomy, as in the case described by Dr. Howard and his colleagues.

This all makes me to reflect a little sadly and shake my not too grey locks and wonder how recent is recent, how old is old. Eheu! fugaces, Posthume, Posthume.—I am, etc.,

SEAMUS F. CAHALANE

Department of Pathology,
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Dublin

1 Cahalane, S. F., and Horn, R. C., *American Journal of Medicine*, 1958, 27, 333.

2 Meachan, G. C., Orbison, J. L., and Heinle, R. W., *Blood*, 1951, 6, 706.

Teaching of General Anaesthesia in Dental Schools

SIR,—Your leading article "Deaths in the Dental Chair" (8 February, p. 293), in common with subsequent correspondence, fails to recognize a contentious point. There is much which suggests that the dentists concerned believed that they were using "intravenous sedation" and not general anaesthesia. If this is so, then dentists are at complete cross purposes with anaesthetists and others who discuss these fatalities. It is instructive to look at the situation from this view.

In your report of the inquest on one patient who collapsed under methohexitone anaesthesia (10 August 1974, p. 419) the dentist, describing his technique, mentions giving a dose of methohexitone and then waiting "for an eyelash reflex" before proceeding to operate. The evident intention is to ensure that the patient is merely sedated and not unconscious; the reason for failure of realization of this good intention is to be

found chiefly in the dentists' education. Accounts given of this suggest that in anaesthesia and sedation their education has sometimes been superficial and empirical in the extreme and has often been based on an anachronistic undergraduate training in general anaesthetics. Dentists do not need "more anaesthetic training" as undergraduates nor "more postgraduate courses in sedation."

The whole of the dentist's education in general anaesthesia and sedation needs radical revision. By default of anaesthetists, the teaching of sedation is so largely in the hands of dentists and so cut off from the discipline of general anaesthesia that it becomes progressively more empirical and therefore potentially dangerous. Dental school practice of general anaesthesia needs complete rethinking if teaching of dentists is to be sound. The application of modern anaesthetic practice in the dental school is feasible; it has been achieved in the dental school of the University of Melbourne and an account of this will be published shortly¹ along with a review of the practical realities of the use of sedation by dentists.

Little will be achieved by mere condemnation of current practice by people who do not understand the problem.—I am, etc.,

J. M. BELL

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Royal Dental Hospital of Melbourne,
Melbourne, Australia

¹ Bell, J. M., *Clinical Dental Anaesthesia*. Oxford, Blackwell Scientific. In press.

G.M.C. and Indian Doctors

SIR,—May I, as an Indian doctor who came here before the N.H.S. came into being, be permitted through your columns to express an immigrant's view on the recent move by the General Medical Council to halt the reciprocal recognition of medical degrees between the U.K. and India (31 May, p. 512)?

There has recently been a marked increase in the number of articles and letters in medical journals casting aspersions on and in some cases suggesting the inferiority of overseas doctors. The Morrison Report¹ has done much to lend support and credibility to these ideas. On reflection it would seem to me that the authors of the report could have had only limited personal knowledge of overseas medical graduates and that their findings were based largely on second-hand information.

Not so long ago overseas doctors were tolerated and even welcomed here just so long as they remained willing to fill the junior hospital posts in the unpopular areas of the N.H.S. It was when they aspired to higher status in hospital services and general practice that the resentment and bitterness began to creep in.

The interests of the Government and the public on the one hand and those of the British doctors on the other would seem to be contradictory. Because of the emigration of British doctors, creating a shortage of manpower previously filled by Irish graduates who now find medicine here less attractive, the Government gave a qualified approval to overseas graduates in order to fulfil their statutory obligation to run a comprehensive N.H.S. In the view of British doctors and their organizations this has frustrated their

hopes of achieving better remuneration and conditions of service.

No country should have to rely on foreign doctors, but let us not make the mistake of inferring that the words "overseas" and "inferior" are synonymous.—I am, etc.,

S. K. ROY

Dagenham, Essex

¹ Report of the Committee of Inquiry into the Regulation of the Medical Profession. London, H.M.S.O., 1975.

Mrs. Castle's Conference

SIR,—I was interested to read of the conference being organized in July by Mrs. Barbara Castle to discuss the contribution of women doctors to the National Health Service (10 May, p. 347). She is quoted as saying: "It is my earnest desire to remove any remaining obstacles to the continuing employment of married women doctors. . ."

The difficulties faced by women doctors wanting to remain within the Health Service are similar to those of nurses and other women health workers. Lack of good child-care facilities are probably highest on the list of obstacles for all women wishing to return to work. Hopefully this conference will not see the women doctors in isolation from the other women in the Health Service. It would also be desirable that not only practising women doctors and medical bodies concerned will be invited, but also that an attempt will be made to include some representatives of women who are not practising, for it is surely these that the conference is aimed at.—I am, etc.,

ANN MCPHERSON

London N.W.5

Politics and Medicine

SIR,—I was disturbed to hear that we are now to have a Conservative Medical Society. As far as I am concerned there is no such thing as Conservative (Tory) medicine any more than there is such a thing as Socialist medicine or for that matter Communist or Nazi medicine. If any measure affecting people's health, the welfare of the profession, or the practice of medicine is for sound logical or scientific reasons desirable, then all doctors must be in favour of it, regardless of their political commitments. If it is undesirable, then all doctors must be against it, no matter what the party platform has laid down. If it is controversial, then it should be debated without the political prejudice that is engendered by societies such as this.

Will this new society be one which any medically qualified Tory M.P. will feel obliged to join even if he is not keen to do so? Will it be a haven for Tory doctors with political aspirations who hope to further their political careers rather than the interests of medicine? Will it, apart from these, have few qualified medical members and consist largely of other Health Service workers? Will it be affiliated to the Confederation of British Industry? Will it be a breeding ground for the "my party right or wrong" attitude?

I call upon all doctors to have no truck with this proposed Conservative Medical Association and to have the courage to resign from its equally objectionable counterpart, the existing Socialist Medical

Association. All the political aims of these organizations can be pursued elsewhere, where the doctor can speak as loudly as anyone else. Their medical aims (including the sociomedical ones) should be pursued, unfettered by party politics, within the profession.

Compared with the above two organizations a Communist Medical Society which openly demanded that medicine should conform to Marxist-Leninist doctrine would at least have the advantage of frankness.—I am, etc.,

A. LEWIS

London W.9

Scottish Assembly and the Health Service

SIR,—Mr. D. N. H. Hamilton's reminder (24 May, p. 446) to the Scottish Committee for Hospital Medical Services of the opportunities to improve the Health Service in Scotland for patients and staff alike presented by the devolution of health care to the Scottish Assembly within the next year or two is indeed timely.

However, his statement that "the desire for a return to a salaried service is widespread in Scotland" is unclear and requires amplification. Firstly, we are all salaried now. Secondly, does he mean a *full-time* salaried service? Thirdly, if so, is he seriously suggesting that this be imposed on all?

Doubtless Mr. Hamilton knows of the existence in Glasgow of several centres of excellence of international repute. In at least one of these most of the consultant staff are part-time and have a high output of academic work, including participation in postgraduate education at an international level. Consultants of this calibre are not going to hang about and be dictated to by politicians as to what kind of contract they may have unless the choice is both wide and reasonable. Are Mr. Hamilton and others aware that the principal effect of any attempt to abolish the private sector of medicine in Scotland would be to deprive our children of the services of some of their own best graduates?—I am, etc.,

J. B. STIRLING

Royal Hospital for Sick Children, Glasgow

Junior Hospital Staff Contract

SIR,—We, members of the junior medical staff of this hospital, would like to add our voices to those of the junior staffs of the Edinburgh Royal Infirmary¹ and of Morriston Hospital, Swansea (12 April, p. 90).

We wish to make clear our lack of confidence in our representatives on the negotiating committee of the Hospital Junior Staffs Group Council. We are currently exhorted to sign forms stating that we will resign or apply "sanctions" at some future date if the negotiations on the proposed 40-hour contract do not fulfil the expectations of our negotiators. This is before we have been given a chance to discuss the proposed contract which is, so far, unseen.

We are opposed in principle to a closed 40-hour contract and reiterate the following points:

(1) The present "open" contract provides sufficient continuity of patient care, practical experience, and training.

(2) Any additional pay for those in the "clinical" specialties will be a temporary gain only, as any Review Body will inevitably take average earnings into account and the basic salary will be depressed.

(3) There must be no financial disincentive to taking university or teaching hospital posts which, by their nature, do not usually involve extra duty payments.

(4) We disapprove of the practice of paying those in different specialties at different rates.

(5) Any further administrative control over medical staff must be rejected.—We are, etc.,

M. A. P. MILLING, A. J. DAY, EARL HOWARTH, P. WAKE, M. R. COLMER, P. HAYES, I. COUTTS, S. ARMSTRONG, S. M. OCKLEFORD, P. A. BURGESS, S. PURBRICK, J. WEBSTER, LYN WALTON, YVONNE BISHOP, J. H. PARR, EMLYN W. JONES, IVAN MORRIS, P. VOSYLUS, PAUL HAYES, J. N. TAYLOR, P. HOLLAND, J. L. EARIS, G. A. PRICE.

Walton Hospital, Liverpool

¹ Kerr, F., et al., *Lancet*, 1975, 1, 796.

Age Limit for Seniority Payments

SIR,—The Department of Health and Social Security appears to ignore the rules that apply to seniority payments.

To recapitulate: (1) Practitioners providing unrestricted general medical services will be eligible for fees and allowances set out by the D.H.S.S. (2) Payments for seniority will be made to every practitioner eligible for a basic practice allowance and who has completed the postgraduate educational requirements. (3) Eligibility for *full* basic practice allowance: (a) provides general medical services and has 1000 or more patients on his ordinary list; (b) is in the opinion of the responsible committee devoting a substantial amount of time to general practice under the N.H.S. The D.H.S.S. consider that the average list of patients of doctors aged 70 and over has fallen below 1500 compared with a national average of about 2400 and give this a reason for the discontinuance of seniority payments, ignoring the rules as stated in (1), (2), and (3) above.

The D.H.S.S. takes upon itself the assumption that there can be few over age of 72 whose ability to provide services remains undiminished. This assumption is disputed by many over 72, being backed up by (3b) above, and there is a shortage of doctors to give service to the N.H.S.¹

Another excuse put forward by the D.H.S.S. is that when a doctor reaches 70 he can receive his N.H.S. and his State retirement pensions unabated even if he continues in practice. This is not relevant and cannot be accepted as a valid excuse for discontinuing the seniority allowance.

Finally, the D.H.S.S. state (AC2 1972/3 para. 59) that many doctors restrict their commitments at this age and it would be inappropriate to continue to pay an allowance which was intended for doctors who can be expected to make a more than average contribution. The D.H.S.S. should note that seniority allowance is not a merit award.

Sir, is there any logical reason for not continuing to pay doctors at the same rate for providing unrestricted general medical services?—I am, etc.,

R. J. S. DOHERTY

Newport, Gwent

¹ *British Medical Journal Supplement*, 1973, 1, 112.