CORRESPONDENCE

We may return unduly long letters to the author for shortening so that we can offer readers as wide a selection as possible. We receive so many letters each week that we have to omit some of them. Letters should be typed with double spacing between lines and must be signed personally by all their authors, who should include their degrees. Letters critical of a paper may be sent to the authors of the paper so that their reply may appear in the same issue.

Correspondents should present their references in the Vancouver style (see examples in these columns). In particular, the names and initials of all authors must be given unless there are more than six, when only the first three should be given, followed by et al; and the first and last page numbers of articles and chapters should be included.

Doctors, science, money, and responsibility

SIR,—I sympathise with the views of Mr K Norcross (29 January, p 391) and echo his call for the very careful long term assessment of new techniques to establish their true worth before introduction into everyday clinical practice.

The pressures on the junior doctor to produce a "piece of research" are already enormous and will no doubt be increased following the article by Professor Philip Rhodes (23 April, p 1341), in the final paragraph of which he presents a Utopian and, I believe, unrealistic view. Good research is, I am sure, "advanced education for the doer," but not all research is valuable because of the reasons for which it is done and by whom. The sheer number of medical journals ensures that with perseverance almost anything can achieve the authority of the printed word, often in a number of different guises. This in turn reduces the standing and credibility of the journal and eventually the other articles it contains.

Increasingly "expensive medical techniques" (5 February, p 417) are adopted without careful assessment because, firstly, the momentum generated by academic departments can be very great and, secondly, perhaps in some measure due to current selection procedures, the up and coming doctor of today wants more than everyday clinical practice—he must embrace, too, the new technological innovation for his fulfilment. The National Health Service as a whole is not a research institute; the priority is the provision of a "best buy" service of comprehensive care for all the population. The service is efficient and value for money and whether we as clinicians like it or not operates within cash limits. Doctors generate the costs of the service[1] and must not use clinical freedom as a licence to squander resources. Every clinical decision must be responsibly evaluated in respect of cost and benefit not only to the patient but to society as a whole. As Professor D N Baron points out (16 April, p 1229), it is necessary for us to audit our work at least within departments. Our colleagues in the United States have a head start on us[2]; perhaps we lag behind because of our single tier consultant structure. We must all do our best to turn our hopes for the service into reality (2 April, p 1079).

What can we do? Every encouragement should be given to the doctor in training, but the pressure to produce a piece of research to ensure advancement must be removed. Let capable investigators in good centres concentrate on producing considered research and improve the overall standards of publications. Let the innovation be evaluated long term in a controlled way so that real benefits are apparent and any added expense of its introduction into routine practice can be seen to be justified. Only a handful of potentially life saving innovations are so important that they must be introduced at once. Above all, it is probably inevitable that a measure of control over expenditure will need to be introduced if we use clinical freedom as an excuse to ignore the costs of the service we provide. My plea is for doctors to exert a measure of control over themselves by acting responsibly and be seen to be doing so if necessary by the introduction of doctors with executive powers. We must not bury our head in the sand and leave ourselves open to government control. At the moment we have a choice.

A P J LAKE

Department of Anaesthesia,
Hope Hospital,
Salford M6 8HD

[1] Akehurst RL. Doctors as spenders. *Hospital Update* 1983;**9**:507-12.
[2] Relman AS. Technology costs and evaluation. *N Engl J Med* 1979;**301**:1444-5.

Aviation medicine

SIR,—Dr F J Mills and Dr R M Harding (23 April, p 1340) state that "patients with air in the cranium may not fly in commercial aircraft." I would like to know if this is a rule made by the airlines or whether the authors have some specific evidence?

Some years ago I had to bring a patient with meningitis and a spontaneous air encephalogram, all due to cerebrospinal fluid rhinorrhoea, back from Portugal on a commercial flight. Once the meningitis had been cleared sufficiently to provide full consciousness and the patient's temperature had fallen it became necessary to close the cerebrospinal fluid fistula, which, for various reasons, could not be done in Portugal.