Talk to him or her and you will be more likely to get the answer you want quickly and safely.

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Proposed siting of the new national clinical research centre

SIR,—Dr J K Cruickshank and others (7 November, p 1211) paint a vivid picture of an allegedly profligate Medical Research Council determined to build on children's playgrounds in order to herd reluctant outpatients from the deserted wastes of Wormwood Scrubs into market style areas in an institution cursed with "primitive hospital facilities." Within this dank, Dickensian edifice are dark corners where ill trained doctors jostle with cockroaches for the cupboard space to perform bronchoscopies. . . .

Most readers' response to their letter must have been a good chuckle at the Saturday breakfast table and a short prayer for selective amnesia. We cannot hope to be as entertaining but we do feel that Dr Cruickshank and colleagues have abused artistic licence and been somewhat economical with the truth in their criticisms of the fabric and postgraduate training experience at Hammersmith Hospital.

Buildings and space previously available have not always been ideal, in common with many other National Health Service hospitals. This has not, however, deterred a generation of patients from having the utmost confidence in the care they have received, nor has it hindered the development of Hammersmith Hospital as a regional and supraregional referral centre of international repute, a status that has eluded many modern, well lit purpose built institutions. It should also be remembered that several other clinical centres, often with even greater financial difficulties, are housed in buildings older than Hammersmith Hospital yet continue to provide first class care. Finally, despite less than ideal facilities, the Royal Postgraduate Medical School has achieved a position of prominence in clinical research, as recently recognised by the University Grants Committee.

We all value pleasant surroundings for patients and staff alike. It is strange that Dr Cruickshank and others glossed over the fact that the new buildings at the Hammersmith site are a modern, purpose built, well lit (and air conditioned) clinical complex designed for outpatient and inpatient care at a cost of £18m and housing a three room endoscopy suite with state of the art facilities for bronchoscopy. Furthermore, there will be new wards, a 10 bed intensive care unit, eight theatres, and a unified outpatient department adjacent to a new pharmacy and comprehensive clinical investigation facilities, including a new x ray department.

We certainly do not contest the value in postgraduate training of dealing with acute admissions in district general hospitals. We feel particularly able to comment as we have recently trained at Ealing Hospital, one of the district general hospitals mentioned by Dr Cruickshank and others. We actively promote the district general hospital experience to our younger colleagues and believe that the department of medicine at Hammersmith Hospital should be commended for its perspicacity in creating rotational registrar training posts with nearby district general hospitals. In the units in which we have worked at Hammersmith Hospital five out of six registrar posts rotate in this fashion.

These posts foster links which effectively provide a population base for training which is much larger than that implied by Dr Cruickshank and others, who confuse quantity with quality by extrapolating from crude admission figures to reach an exaggerated criticism of the ability of the new centre to provide adequate experience for young doctors. Many of the admissions to Hammersmith Hospital are of a complex nature and furnish a rich vein of further clinical experience which continues and enhances general training. This experience has led many doctors to progress to research projects which have provided insights into the treatment and pathogenesis of diseases both common and rare. It should not need to be stated that many of the juniors receiving this training have gone on to achieve national and international prominence in their specialties.

The exciting prospect of the new centre should not be obscured by criticisms which, in the main, seem peevish rather than constructive.

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SIR,—The merger between the Clinical Research Centre at Northwick Park and Hammersmith Hospital Royal Postgraduate Medical School has been decided and if certain provisos can be met the site chosen will be in Du Cane Road. It is sad that at this late stage Dr J K Cruickshank *et al* (7 November, p 1211) are trying to reverse this decision. Surely the points raised by them have been known to those who made the decision. It is this sort of rearguard action which delays the resolve to merge and could delay it even longer. Delay will hurt not only both centres but also medical research in general because of the lack of adequate funding.

I had a happy interaction with members of the Clinical Research Centre for many years both on the clinical side and in basic research. I found those working in basic research especially helpful, and so I am looking forward to the time when we are going to work on the same site and thus have more effective cooperation. Please, now that a decision has been taken could we look towards the future and look at what is positive in the merger and work towards its rapid implementation together?

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Monitoring the safety of over the counter drugs

SIR,—Dr Glyn Volans has raised important issues about the detection of adverse effects from non-prescription medications (30 October, p 797). He seems to play down what we view as the central role of the voluntary reporting schemes run by national centres throughout the world.

While we concede that voluntary reporting schemes have limitations, they remain the mainstay of adverse reaction evaluation and, if run flexibly, can monitor prescription and non-prescription medications. Recent Australian experiences of regulatory decisions affecting non-prescription drugs and consumer products which were based wholly or in part on voluntary reports to the Adverse Drug Reactions Advisory Committee reinforce this view.

In 1980 a pediculocide shampoo, A200 pyrinate, was withdrawn and reformulated after reports to the committee of conjunctival inflammation and corneal ulcers in children. In 1982 eight reports to the committee, coupled with other published Australian cases, of hypertension with phenylpropanolamine hydrochloride when used in high doses as an appetite suppressant led to restriction of its use to smaller doses in decongestant preparations only.[1] In 1985 the committee was alerted to the dangers of oesophageal obstruction due to rapid swelling of glucomannan fibre in tablet form, which was being promoted in pharmacies and health food stores as a bulk forming appetite suppressant. The committee received eight reports of partial or complete oesophageal obstruction; six of these patients required rigid oesophogoscopy, which in one case was followed by serious complications. These reports led to a ban on glucomannan in tablet form in Australia.[2] Reports to the Japanese, United Kingdom, and Australian centres of agranulocytosis and neutropenia resulted in the antihistamine mebhydrolin napadisylate being rescheduled to prescription only in the United Kingdom, West Germany, and all but one Australian state.[3]

In all of these cases much or all of the motivation for action in Australia came from reports received during routine operation of the national voluntary reporting scheme. In the case of mebhydrolin and glucomannan the signals were strengthened by responses to items published in the adverse drug reactions bulletin. These were serious reactions to non-prescription products and we believe that if, as Dr Volans suggested, the primary responsibility for safety monitoring had lain with the manufacturers the publicity and appropriate regulatory actions could have been delayed.

We support Dr Volans's suggestion that pharmacists should be encouraged to collect and report adverse reactions to drugs. The Australian committee receives reports from community pharmacists, which make up about 5% of the total. These reports concern both prescription and non-prescription medications. Of the reports which identified the reactions listed above, only one was submitted by a retail pharmacist, but most of those reactions were serious and were likely to lead directly to medical intervention. Pharmacists may have an important role in identifying and reporting less serious adverse drug reactions.

Finally, one source of information on adverse reactions not discussed by Dr Volans is the consumer. Most national reporting centres do not encourage large scale self reporting of adverse reactions by patients, and any scheme should be fully evaluated before being recommended for implementation. An example of such a programme, supported by a grant from the National Health and Medical Research Council of Australia, is presently being tested, and the initial results were presented at the third international conference on pharmacoepidemiology (A S Mitchell *et al*). If this system proves successful then it may be particularly suited to the monitoring of non-prescription drugs.

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3 McEwen J, Strickland WJ. Mebhydrolin napadisylate: a possible cause of reversible agranulocytosis and neutropenia. *Med J Aust* 1982;ii:523-5.