Correspondence

Letters to the Editor should not exceed 500 words.

Dopa for Parkinsonism J. M. Potter, F.R.C.S.	714	Extra-articular Manifestations of Rheumatoid Arthritis F. Dudley Hart, F.R.C.P.; A. G. Mowat, M.R.C.P.ED.	717	Drugs for Cardiac Arrhythmias D. A. L. Watt, M.R.C.P.	719
Pattern of Social Reform H. Wapshaw, F.R.C.S.ED.	715	G.M.C.'s Annual Levy A. K. Maitra, F.R.C.S.	717	Peritoneal Dialysis and Lysol Poisoning B. B. Thomas, M.R.C.P.ED.	720
How Many Surgeons? J. Duguid, M.B.	715	Life-tables for Cystic Fibrosis L. George, M.D., D.C.H., and A. P. Norman, F.R.C.P.	718	Analgesic Neuropathy J. H. Shelley, M.B.	720
Medical Staffing in the N.H.S. H. T. John, F.R.C.S.	715	Depressive Changes Following Fluphenazine Treatment J. Johnson, M.D.	718	Malmström's Vacuum Extractor J. A. Chalmers, F.R.C.O.G.	720
Violence on T.V. P. D. Scott, M.R.C.P., D.P.M.; P. G. McC. Banister, M.B.	715	Hospital Letters V. S. Nehama, D.P.M.	718	Sickness Certification M. T. Wade, M.B.	720
Subnormal Hospitals L. Arenillas, D.P.M.; K. S. Jones, D.P.M.	716	Bowel Innervation in Hirschsprung's Disease J. R. Garrett, PH.D., M.C.PATH., and others	718	How Many Authors Can Collaborate? K. J. Plasterk	721
An Explanation for Addiction J. B. Stetson, M.D.	716	An Aid to Cholangiography R. T. Burkitt, F.R.C.S.	719	The Consultant's Job N. A. Simmons, M.B., M.C.PATH., and others	721
Awareness during Anaesthesia J. Wilson, F.F.A. R.C.S., and D. J. Turner, F.F.A. R.C.S.	716	Which Dialyser? W. K. Stewart, M.R.C.P., and others	719	Doctors and Overtime Pay D. L. McLellan, M.B.	721
Myoedema and Vitamins A. N. Patel, M.D.	716			Dispensing Doctors and Pharmacists B. D. M. Williams, B.M.; T. D. Richards, M.D.	721
Trimethoprim for Malaria L. J. Bruce-Chwatt, M.D.	717			Armed Forces Pay "Contented Retired Officer"	721

Dopa for Parkinsonism

SIR,—Despite its actual and potential disadvantages, many doctors and patients (and, according to some reports, black-marketeers) are already convinced that Dopa gives far more effective relief from some of the disabilities of Parkinsonism in certain patients than does any drug freely available in this country. It has been clear to some of us for some time that more than a *prima facie* case was established by the careful studies of the respected American scientist Dr. George Cotzias and his co-workers,¹ whose claims were modest, but firm, and expressed with proper scientific caution.

Now, more than two years after Cotzias's first publication, the discouraging, lukewarm statement issued by official bodies² will have come as a great disappointment to those doctors and patients who had been waiting to hear that there would at last be facilities for all patients who might benefit from this drug—and who were prepared in their extremity to risk possible ill effects—to receive it under supervision. I should like to suggest that protracted official caution about the safety of Dopa, although entirely understandable, is inappropriate to the present situation. Is Cotzias's work not acceptable and, if not, what further clinical trials are to be carried out that are expected to add significantly to his evidence and to the experience of others who have been using it for some time that the drug is reasonably safe in relation to the circumstances which may call for its trial? For how much longer are the trials expected to be needed, and are they to be concerned only with safety or does someone still seriously doubt that Dopa's effects can be strikingly beneficial?

Certainly there may be potential hazards from sudden withdrawal, but I am not aware that any prohibitive effects have yet been reported. On the contrary, the evidence so far indicates that, unlike some forms of replacement therapy, Dopa carries the advantage that the symptoms which it has

mitigated do not immediately reassert themselves when the drug is discontinued, but remain in abeyance, usually for a few days and sometimes for much longer, until perhaps a store of dopamine has again become depleted. By omitting a dose before, say, they go out in the evening, those who have troublesome involuntary movements for a little while after each dose can avoid the embarrassment that these movements may cause in public. Those who show temporary granulocytopenia or some other symptom, such as haematuria, which might be an effect of the Dopa, may discontinue the drug for a longer period without losing its benefit for all of the time. Other side-effects, which are certainly undesirable, are nevertheless often tolerated in order that the desirable effects may continue. Good may even come with the bad; not only has one patient I know endured nausea patiently, but it has helped to reduce his obesity, which was aggravating the defect in his gait.

The observation in the last sentence of the official statement, that only a proportion of patients may be expected to benefit, is irrelevant to those who may do so—they just want the chance. Doing the best one can with the knowledge and facilities available is surely what medicine is all about. Do the profession and the public really want expert committees and the Department of Health to deny patients the opportunity to decide whether or not they will accept these kinds of risk? One knows that, apart perhaps from the financial aspect, the intention of the authorities is altruistic, but whether the inseparable flavour of paternalism is good for medicine in the long run is debatable. Could not all the sufferers from advanced Parkinsonism be allowed to decide for themselves whether they would prefer to accept all risks now, rather than wait for an indefinite period for official blessing? If this were permitted, the large-scale experiment would indicate the safety of Dopa quickly, and might it not

be more appropriate at this stage for the M.R.C. to encourage research into why, as has already been established, this drug helps some patients and not others, and towards the development of potentiating agents?

Turning to the financial aspect, there is no mention of cost in the joint statement, but the sums mentioned in the lay press do not seem to be very great in relation to other Health Service costs, to the general expenditure on drugs, or—for that matter—to the cost of British justice, which is now said to be running at some £30 per minute. Indeed, £1 per day spent on Dopa would be an economy if it kept a patient out of hospital or saved the expense of a series of less effective thalamic operations.

There are important principles in this situation which are a proper subject for debate, and I am sure that my bewilderment must be shared by others. The official caution that has been shown over the past two years, and our resulting slow progress in the wake of American research into what is perhaps the most promising of all recent advances in the treatment of nervous disease, is regrettable. It is the duty of the Department of Health and its medical advisers to protect the public and the reputation of the N.H.S. against grave errors resulting from hasty new therapy and the spared judgement of the few. But it is essential that the cautious, detached, long-term approach should at least be questioned. Although given to us in rather a different context, Medawar's aphorism, "Present skills are sufficient for present ills," expresses neatly the general truth that I am trying to labour.

May I suggest that L-Dopa (or, if expense is an insuperable obstacle, even commercial DL-Dopa) be made available to every general hospital from which there could be reasonable supervision of all those who are sufficiently incapacitated by Parkinsonism to justify its trial and who are prepared to accept its as yet unknown risks? There will be fear that this drug would be abused. Certainly, it would be if it were more freely

available. What new drug or surgical operation isn't? So too, British Railways have said, would seats be abused if they were provided for the convenience of the public at Euston Station.—I am, etc.,

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REFERENCES

- ¹ Cotzias, G. C., Van Woert, M. H., and Schiffer, L. M. *New England Journal of Medicine*, 1967, 276, 374.
- ² Joint Statement by the Medical Research Council and the Department of Health and Social Security. *British Medical Journal*, 1969, 3, 481.

Pattern of Social Reform

SIR,—When reform is the order of the day everybody gets the yen to change something. At first real contingencies exist justifying the reform, but, as is so apt to happen, changes are made simply for the sake of change as in the fashion world. Sooner or later we all get the longing to go back to something.

What prompts these tendentious remarks is the address of Sir George Pickering (16 August, p. 375). Allowing for the fact that he was gracing an occasion, it would be ungracious of me to take exception to any of the opinions. How could one, when all the Utopian conditions that he prayed for already exist north of the border? The curricula of the Scottish schools have always been broad and elastic to suit the "lad o' pairts," and, of course, egalitarian; none of our ancient universities claim that their alumni are finished products, and our notice-boards are cluttered with intimations about this or that postgraduate activity. It is not my purpose to expatiate on the long tradition of Scottish education—one that goes back to James IV's reign, when in 1494 a statute was passed making it compulsory for every freeholder's heir to learn "perfect Latin"—but to draw your readers' attention to the threat of a wholesale switch to the comprehensive system of school education—and all because of problems which exist in England and Wales.

Taking the yardstick of comparison of the minimal requirements of entry to university, which is three English A levels as against our four *good* higher, we might suppose that English pupils are the more learned and the Scots the more cultured, but who is to say which is the better educated? The University of Wales has announced a new degree by which it hopes to bridge the gap between the basic humanities and the basic sciences through the introduction of logic and linguistics into the B.Sc. course. I note that the chairman of the committee responsible for creating these would-be literary scientists is Professor Michael McSwann, the Vice-Chancellor of Edinburgh University.

As for the lessons of history, they are there to be taken or left. The twelfth-century scholastics, who paved the way for the foundation of the university, sought their inspiration in Aristotelian philosophy. Thomas Linacre made Galen his model; Thomas Sydenham preferred Hippocrates; and Sir George quotes Plato and commendably completes the regress by invoking God Almighty.

There must be many like myself who have a deep-rooted objection to calling our refor-

mation a revolution. If we must think that way let us bear in mind that revolutionary movements either revolve round their prime mover or end very much as they began. Hippocrates regarded medicine as the noblest of the arts. After Linacre it was upgraded to a learning, and for the past century medical thinking has been bedevilled by the circular argument of art versus science. Now we are being conditioned to think and talk like engineers. It does not require a classical education to know that technology is the science of the arty-crafty. Why must we always have to qualify medicine?

This much can be said for thinking in terms of a renaissance—that following a rebirth we can expect to hope for a stage when we shall all grow up to respect discipline and reach that degree of maturity when ends are distinguishable from means. As Hippocrates reminds us: "Medicine was invented for the sake of the sick."—I am, etc.,

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How Many Surgeons?

SIR,—As a general practitioner I have met too many frustrated surgeons, forced to emigrate or go into general practice, not to sympathize. Mr. P. F. Jones's excellent paper on the training and selection of surgeons (23 August, p. 464) is long overdue, and should be implemented as soon as possible, mainly by reducing entry into this specialty of potential trainees.

If a surgeon becomes a consultant at 35 he has a potential professional life of 30 years before retiring at 65. Thus one surgeon should start training for every 30 in active practice. As the training period lasts ten years, mainly as a registrar, 10 trainees per 30 surgeons will be necessary. This means that every fourth practitioner of surgery will be a registrar.

The figures on hospital staffing (23 August, *Supplement*, p. 103) show for England and Wales 893 consultants and 681 registrars in surgery—a total of 1,574. If my figure of one in four were accepted, the number of registrars would be reduced to 394 and the numbers of consultants increased by 287 to 1,180. In round figures there should be an increase of one-third in the number of consultants by 300 up to 1,200. This increase would represent the junior consultant grade advocated by Mr. Jones.

I would further juggle the figures so that senior consultants would be reduced to 800 and junior consultants increased to 400. A final picture would emerge of 1,600 surgeons divided into: senior consultants 800, juniors 400, and registrars 400. Broken down, this would give a "firm" of two seniors, one junior, and one registrar. The new appointments would have to be implemented slowly at regional level as the present senior consultants retire. Promotion should be supervised by three nominated senior consultants responsible for training, one from regional hospitals, one from a teaching hospital, and one nominated by the Royal College of Surgeons.

I have analysed the other specialties and applied my new scale to them. In some specialties—for instance, orthopaedics—where

consultants and registrars are roughly equal, a wait of 30 years would have been necessary before achieving consultant's rank. This seems grossly unfair in a specialty where the casualty officer seems tailor-made for the post of junior consultant.—I am, etc.,

J. DUGUID.

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Medical Staffing in the N.H.S.

SIR,—In the *Supplement* (23 August, p. 103) you publish Tables on medical staffing in the National Health Service in England and Wales. As far as I am able to determine from the Tables, no account has been taken, once again, of the large number of potential applicants for consultant posts who are at present employed in university departments.

To ignore this large number of potential applicants, in a specialty such as general surgery, makes the Tables not only inaccurate, but dangerously misleading to a young man estimating the career prospects in any particular specialty. It would be helpful if the Department supplied these figures as well—I am, etc.,

H. T. JOHN.

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Violence on T.V.

SIR,—I think Dr. J. A. Ardis (9 August, p. 361) is justified in objecting to a clear distinction between endogenous and exogenous influences, for obviously all action must always be a resultant of both; in this sense the word endogenous could have been better expressed as "lacking clear provocation from the environment." As examples, if a depressed man kills his innocent family and himself, or if a paranoid person shoots at the postman, or a catatonic schizophrenic patient suddenly strikes his helpful physician with a Winchester quart bottle, it seems fair to say that the principal causative factors must be within the patient rather than in the immediate environment, and that is surely what is meant by the statement that the aggressive action of psychotic persons "is likely to be *mainly* endogenous."

Dr. Ardis suggests that the psychotic "sees more clearly than is normal," and that his perception is widened or narrowed or different in some way, but surely this is irrelevant to the exogenous-endogenous dilemma. The disorder of attention or perception might be due to a morbid state of the reticular system and thus mainly endogenous.—I am, etc.,

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SIR,—Your leading article "Violence on T.V." (19 July, p. 125) leads me to point out another problem presented by these programmes. Not only does this "school" not teach that violence itself is something reprehensible, but it encourages immature viewers to believe violence has very little significant effect. A child is easily confused by incongruities. How is it that the private investigator, having been attacked by three or