critical of the present situation. There is no doubt that Sir Keith Joseph, the Secretary of State for Social Services, is deeply interested in the development of realistic medical rehabilitation and many of us hope that this will prove possible now, and that the Tunbridge Report will not be allowed to gather dust in the way that previous reports have done.—I am, etc.,

JAMES G. SOMMERVILLE

Medical Rehabilitation Centre,
St. Charles's Hospital Group,
London N.W.1

¹ Sommerville, J. G., *Proceedings of the Royal Society of Medicine*, 1970, 63, 1146.

² Department of Health and Social Security, *Rehabilitation*. H.M.S.O., London, 1972.

B.M.J. and Clinical Medicine

SIR,—The *British Medical Journal* is one of the few English-language journals of medicine which remain uncommitted to any particular medical or scientific discipline. As such it has a wide readership drawn from those engaged in the fields of academic and clinical medicine and research and has wisely maintained a responsible balance between minority and majority opinion.

Notwithstanding these general introductory comments, I am of the opinion that the essential role played by the *B.M.J.* in undergraduate and postgraduate education lies in the field of basic clinical and applied medicine and that this historic tradition should be vigorously maintained. In recent years I have had the impression that the journal is tending to abandon this primary role. There are now sufficient journals, and some may well say too many, devoted to pure scientific data and research and there is surely no need for the *B.M.J.* to attempt to emulate contemporary scientific literature at the expense of clinical and applied medicine.

In support of my thesis, let me take just one recent example from a carefully compiled and comprehensive report by Dr. D. I. Grove and others regarding immunological function in dystrophonia myotonica (14 July, p. 81). It is certainly not my intent to criticize the scientific data and indeed I do not consider myself competent to do so, but I am competent to criticize the fact that the only clinical information about dystrophonia myotonica imparted to your readers was that the disease "is a multisystem disorder" and that each of the 15 patients investigated "had characteristic clinical features." I am thus led to the conclusion that the authors felt that we all would know, or if not should know, what are the characteristic clinical features in this uncommon condition and that any further clinical details would be regarded as being superfluous to this study of humoral and cellular immunity.

Medical authors, like biographers and novelists, will only succeed in having their work read if it is presented in such a form as to be of interest to the reader for whom it is intended. It is not, I would suggest, due to indolence or ignorance that so much of the contemporary written word is unread as compared with the epic clinical writings of the past.

In this modern age we find it far easier and less time-consuming to neglect careful clinical appraisal of our patients and instead submit them to innumerable investigatory procedures. Moreover, as clinicians, our task

is made no easier by the concept of bureaucracy that efficient medical management lies in the conveyor-belt system of medical practice. My plea is that the *B.M.J.*, assessing its own pertinent role in modern scientific journalism, should assert positively its heritage in clinical medicine.—I am, etc.,

ANTHONY FREEMAN

Princess Margaret Hospital,
Swindon, Wilts

Late Advertising of Hospital Posts

SIR,—Professor R. S. Illingworth asks (4 August, p. 289) why so many junior hospital posts are advertised so late.

With his illustrious reputation there is almost certainly a queue of British graduates anxious to work in his department in Sheffield. We in the periphery, on the other hand, have learnt to our cost that non-U.K. graduates will look around for the best job they can get, and they have no qualms whatever about taking another post even after being appointed to one. On one occasion I was not even informed that the man was not coming. Inquiries were made on his failure to appear and it was found that he had already started elsewhere. This meant a delay of several weeks before another appointment could be made and the hiatus was acutely felt in a small hospital such as this.

Under these circumstances one is inclined to appoint the person who is free to start at once to make sure of getting help. On two occasions this has led to the appointment of a totally unsuitable applicant with near-disastrous results. One is now tempted to withhold the appointee's interview expenses until he actually takes up the appointment.—I am, etc.,

S. T. H. JENKINS

Bronglais Hospital,
Aberystwyth

Complaints against Doctors

SIR,—I recently received a letter of complaint through my executive council couched in almost entirely hearsay terms. I agreed to attend the executive council offices on the basis of the informal procedure, in the naive belief that there would ensue a cool discussion of certain medical points, based on unremarkable hospital and personal records.

Subsequent to a private hearing of the complaint, I was informed by the medical member in this procedure that there was no point in discussing any evidence I had to offer, that the case would go forward for the consideration of the chairman of the medical services committee who would, in the opinion of the member, order an inquiry.

Every general practitioner would be well advised to obtain from his executive council a copy of ECL 46/68, relating to the informal handling of complaints about general medical services, and to note that nowhere in this document is there reference to the validity of diagnosis, treatment, or care afforded to the patient, or even of simple regard to medical evidence.

The doctor can already be assailed through the courts, the G.M.C., and the formal procedure. The informal procedure though optional affords yet another avenue of com-

plaint, as usual without let or hinderance, against the family practitioner and one in which the traditional defence of medical evidence and of sound medical practice may be disregarded.—I am, etc.,

RALPH H. EVANS

Norwich

SIR,—That doctors and patients clash is known and is now well documented both in the book by Mr. R. Klein¹ referred to in your leading article (30 June, p. 729) and in figures available from the House of Commons library.

What can be inferred is that a family doctor entering practice must expect to have to submit to the formal procedure some time, and to be called every few years under the informal procedure, and to be subjected to direct abuse to his face every few months, and to have secondhand complaints via his partners or staff at similar intervals. On the credit side he can expect to get to know his patients well enough to ask after their families after being in practice about 10 years and can expect Christmas cards and the odd bottle then too.

For every complaint there is a waiting time of stress until the verdict is known, either from the EC22A "N" category, and some of the "X" ones, or from the grey duplicated sheets minuting his performance at the hearing. This leaves, on average, every doctor under continual assault without any redress collectively or singly to point out the 99% of successes. For God's sake let us have costs in unjustified cases—the patients leave us as it is.—I am, etc.,

M. J. JAMESON

St. Albans, Herts

¹ Klein, R., *Complaints against Doctors*. London, Charles Knight, 1973.

Haemophilus influenzae Apparently Resistant to Trimethoprim

SIR,—We have read with interest Dr. S. R. M. Bushby's report (7 July, p. 50) on our strains of *Haemophilus influenzae*. We note that he confirmed our basic observation of the ability of many of them to grow in the presence of concentrations of trimethoprim far in excess of the usual minimum inhibitory concentration for the species, but his interpretation of the significance of the phenomenon differs from ours. We would like to make the following points.

(1) Dr. Bushby has himself been very largely responsible for the world-wide acceptance of the use, in tests of sensitivity to sulphonamides and trimethoprim, of the media that we used, and yet he suggests that the presence of thymidine or thymine in these media may have been responsible for the apparent resistance of our strains. He cannot have it both ways, unless he is suggesting that *H. influenzae* behaves differently from other organisms in this context.

(2) *H. influenzae* grows very poorly on these media, even with the addition of X and V growth factors, and 90% inhibition, to which Dr. Bushby refers as the customary growth level at which to read the end-point, would denote colonies of almost microscopic size. The minute colonies described in our paper can be seen with the naked eye and can safely be regarded as indicating less than 90% inhibition.

(3) Dr. Bushby states that "the organisms

giving the long trailing end-points were... morphologically abnormal and mostly dead" and "the few viable abnormal forms... assumed normal morphology when transferred to trimethoprim-free medium." The latter observation supports our view that, in the context of practical chemotherapy of chronic infections, these strains must be regarded as drug-resistant. Promotional literature relating to trimethoprim/sulphamethoxazole mixtures stresses their bactericidal activity. This may be so under controlled conditions *in vitro* but, as pointed out elsewhere^{1,2} the relapse of infection usually suffered by patients with chronic haemophilus respiratory infections after treatment with such mixtures is entirely similar to that following bacteriostatic drugs. The discrepancy can be explained by the poor penetration of sulphamethoxazole into respiratory secretions,³ which has the result that response to treatment is effectively the response to trimethoprim alone—a bacteriostatic drug. In such circumstances Dr. Bushby's demonstration of the ability of even a few organisms exposed to high concentrations of trimethoprim to revert to normal forms in subculture is entirely compatible with our belief that these forms must be regarded as drug-resistant.

(4) Dr. Bushby refers to his experience of the response to trimethoprim of mice infected with our strains. However, little significance can be attached to such studies in the context of chronic human infection, because mice, like other laboratory animals, are susceptible to infection by noncapsulated *H. influenzae* only when injected with enormous numbers of organisms—a situation bearing scant resemblance to the natural situation.

We have no doubt about the value of trimethoprim in the short-term treatment of many patients with acute infections or acute exacerbations of chronic ones, but it has been disappointing in the bactericidal therapy of chronic infections of the respiratory tract. As with other drugs with a similar limitation a natural consequence may be a tendency to prescribe the drug for prolonged periods in individual patients. We feel that a logical conclusion to be drawn from our findings is that trimethoprim should not be used in this way in respiratory disease, or indeed be prescribed at all without a clear indication for it, such as failure of response to ampicillin or tetracyclines. The emergence of resistant organisms provides a warning that indiscriminate prescribing may result in the loss of effectiveness of the drug in situations where at present it is often of great value.—We are, etc.,

J. ROBERT MAY
JUDITH DAVIES

Institute of Diseases of the Chest,
London S.W.3

¹ May, J. R., *Postgraduate Medical Journal*, 1972, 45, November Supplement p. 94.

² May, J. R., *Chemotherapy of Chronic Bronchitis*, 2nd edn., p. 63. London, English Universities Press, 1972.

³ Reeves, D. S., *Journal of Clinical Pathology*, 1971, 24, 430.

Fashions in Infant Feeding

SIR,—Your leading article (30 June, p. 722) drew attention to the lack of published information on the composition of the urine of infants fed high solute loads. The following results were obtained from normal controls during a study of urine composition in infants with heart failure. The infants were

TABLE I—Urinary Solute Concentrations (Mean $\pm$ S.D.) in Infants Fed on Different Feeds

Feed	No. of Infants	Sodium (mEq/l.)	Potassium (mEq/l.)	Urea (mg/100 ml)	Sodium (mEq/l.) Creatinine (mg/100 ml)
S.M.A.	9	20 $\pm$ 11	28 $\pm$ 10	504 $\pm$ 451	1.5 $\pm$ 1.0
Non-humanized milks . .	12	49 $\pm$ 40	80 $\pm$ 45	1,493 $\pm$ 861	1.7 $\pm$ 1.2
Weaning diet	18	57 $\pm$ 48	60 $\pm$ 38	1,117 $\pm$ 642	2.2 $\pm$ 1.6

aged 11-314 days and were receiving Similac (S.M.A.), non-humanized cow's milk, or weaning diets. Results are from random urine specimens collected between 2 and 4 p.m. Urinary sodium, potassium, urea, and creatinine concentrations were measured by AutoAnalyzer and urine osmolality with an Advanced osmometer.

As shown in Tables I and II urinary sodium, potassium, and urea concentrations and urine osmolality were significantly higher ($P < 0.02$) in infants fed non-humanized milk or weaning diet than in those fed on S.M.A.

TABLE II—Urine Osmolality of Infants fed on Different Feeds

Feed	No. of Infants	Urine Osmolality (mosmol/l.)		
		Mean	S.D.	Range
S.M.A.	8	236	121	91-401
Non-humanized milks . .	10	544	285	97-1,000
Weaning diet	9	532	259	167-1,000

The normal urinary concentrating power of infants fed high-protein diets is 1,200-1,400 mosmol/l.¹ Since two infants in this small group were passing almost maximally concentrated urine, it is easy to speculate upon the likely effects of extra water loss.—We are, etc.,

H. RICHARDSON
CYRIL CHANTLER

Department of Paediatrics,
Guy's Hospital,
London S.E.1

¹ Edelmann, C. M., *Pediatrics*, 1973, 51, 854.

SIR,—Dr. R. K. Oates (30 June, p. 762) has done a service in pointing out so clearly the faults that commonly occur in preparation of infant feeds. Of particular importance in his series is the fact that of 90 mothers using dried milk formulae nearly one-third prepared milk that was too concentrated or too dilute. Experience has shown that this kind of error is compounded by variations in mixing instructions that occur with different brands of dried milk.¹ Quite apart from mothers, it is clear that doctors, health visitors, students, and nurses become confused by the lack of standardization.

Recently the South African Paediatric Association, in conjunction with the South African Metrickation Board, has managed to persuade all dried milk manufacturers in South Africa to adopt a standardized dried milk dilution as from 1974. For unmodified milk formulae the dilution is to be one 5-ml teaspoon (or scoop) to 25 ml of water, and for modified milk formulae it is to be one scoop (size determined and provided by the manufacturer) to 25 ml of water. All feeding bottles are to be standardized to 250-ml size with 25-ml divisions. Instructions

to mothers can then be simplified to one teaspoon or scoop per division on a bottle whatever milk powder is used. It is hoped that this innovation will reduce errors of excessive concentration and dilution.—I am, etc.,

J. D. L. HANSEN

Department of Paediatrics,
University of the Witwatersrand, Johannesburg

¹ Hansen, J. D. L., Leary, P. M., Anderson, J. H., and Robertson, I., *South African Medical Journal*, 1970, 44, 1312.

Testing for Tay-Sachs Carriers

SIR,—May I ask for the hospitality of your columns to offer a diagnostic service?

Tay-Sachs disease is a fatal condition, death occurring after about three years of distressing illness. It is due to autosomal recessive inheritance, so both parents must be carriers. If we could identify them, amniocentesis could be done between the 14-16th weeks, in time to offer abortion if the fetus had the disease. Carriers can now be detected as their blood contains amounts of the relevant enzyme (hexosaminidase A) which lie between those of affected infants and of non-carriers. The carrier state is 10 times as common in Ashkenazi Jews as in the general population, so there is a good argument for starting a testing programme among Jews. This has been done in Baltimore, Washington, Toronto, Montreal, and other North American cities.

We have set up a laboratory for such testing and we would be glad to visit groups (in synagogues, colleges, etc.) to obtain 5-ml specimens of blood. By appointment individuals can visit this hospital for testing; relatives of affected children will be particularly welcome. The only exception is of women more than 17 weeks pregnant—that is, too late to permit cell culture in time for safe termination, but still with many weeks to worry in if both her and her husband's tests are in the danger zone.—I am, etc.,

PHILIP EVANS

Director, British Tay-Sachs Foundation
Hospital for Sick Children,
Great Ormond Street,
London, W.C.1

Laparotomy during Pregnancy

SIR,—While agreeing with Drs. Peter Saunders and P. J. D. Milton (21 July, p. 165) that the risk of precipitating labour following a negative laparotomy during pregnancy is extremely small, it seems illogical that the additional surgical procedure of removal of an easily accessible normal appendix should increase the fetal mortality so dramatically. Furthermore, three fetal deaths in seven patients are small figures on which to base such a