women with postphlebitic limbs and marked secondary skin changes, who challenge the efficacy of any form of treatment. For them more complex investigation by methods such as directional Doppler, stereovenography, and fluorescein retrograde staining at surgery may be required. Certainly these patients are still best treated in specialist centres if much useless effort is to be avoided. In spite of accurate anatomical diagnosis the results in the best of hands remain poor, and the hope must lie in more effective prevention of the end-stage unstable skin, fibrotic cuirass, or varicose ulcer. With rational early treatment now beginning to look a possibility greater stress on prophylaxis becomes more realistic.

3 Linser, P., Medizinische Klinik, 1916, 12, 897.
12 Hobbs, J. T., Archives of Surgery, 1974, 109, 793.

Ask Your Friendly Pharmacist

General practitioners whose waiting rooms are crowded out at this time of year are only too willing to agree that many of their patients’ complaints are trivial and self-limiting; yet paradoxically they tend to resent any attempts by other health professionals to take over the treatment of these minor illnesses. There is a fundamental conflict between the theoretical ideal in which every individual has immediate access to medical diagnosis and advice and the practical possibilities when one doctor looks after 2000 or more potential patients.

The current economic problems of the N.H.S. have reawakened interest in the possibilities of self-treatment. Minor episodes of diarrhoea and vomiting, sunburn, mosquito bites, headache, and a whole range of trivial injuries can and probably should be treated at home, and the Department of Health could perhaps do more to encourage such a trend. Often, however, the sufferer wants to ask someone about the best treatment; and often the person whose advice is sought is the local pharmacist—and indeed pharmacists have been finding that their help is being asked more often nowadays as appointment systems proliferate in general practices. Last week Which? published a survey of the treatment given by pharmacists to investigators from the Consumers’ Association and found that on the whole the advice and therapy given was sound; but the survey also showed up some of the potential hazards of the practice.

Arguably, the customer who asks the pharmacist’s advice does so on the basis of his own diagnosis—he is asking for expert assistance in selecting treatment, not in identifying the cause of his symptoms. In practice, of course, the pharmacist often has to ask a few questions to help him to decide what the patient means by “stomach ache,” and the experienced pharmacist may well become a shrewd diagnostician. So far so good; it is the patient who chooses to go to the pharmacist rather than “trouble the doctor.” However, if encouragement is to be given to this kind of self-treatment by patients, there should perhaps be greater willingness by pharmacists to advise their customers to see a doctor. The Pharmaceutical Society recommends its members to tell their customers to consult their doctors if symptoms persist for more than three or four days; yet in the Which? survey less than half the pharmacists did this even when the symptoms described could have been due to serious illness. Some of this reluctance to recommend seeking a medical opinion may be due to a defensive attitude by pharmacists, partly explicable by the unresolved dispute between them and rural doctors about dispensing. Generally, however, the two professions recognize and respect each other’s skills and special knowledge. Pharmacists have a long tradition of over-the-counter medical prescribing; and they, the medical profession, and the public can all benefit from a sensible recourse to growth of this practice so long as its limitations are clearly recognized by all concerned.

1 Which?, March 1975.

How Open is Open?

Will the Government ever get the message? Most consultants are tired of their good will and voluntary efforts being used to support a creaking hospital service. That, essentially, is why their dispute (4 January, p. 4) with the Government continues. No amount of semantics about how open is an open-ended contract will convince these experienced doctors that their employers have not taken an increasing—and unfair—advantage of the vagueness of their present terms of employment. Mrs. Castle’s recent House of Commons statement and the subsequent parliamentary exchanges (page 636) will do little to promote a constructive solution to this unhappy dispute.

The Prime Minister in his replies to the B.M.A.’s requests for a meeting—his second letter is at p. 642—concentrates on two matters: the forthcoming pay review and the definition of the consultants’ contracts. Clearly, the Government hopes that the Review Body will recommend an award which, if promptly approved by the Cabinet, will deflate the consultants’ anger. Indeed, one sentence in his second letter may foretell its post-award tactics: “But I cannot think that the profession—or the Review Body—ever believed that these consultants were being paid for contracts so limited in scope.” Does this imply that the Government will not implement any award while the work to contract continues on the grounds that the Review Body has basd its recommendations on a completely open-ended commitment?

Not many consultants would agree with the Prime Minister’s interpretation of the late Mr. Richard Crossman’s parliamentary statement on consultants’ contractual hours of work. Nevertheless, Mr. Wilson’s second letter is a skilful public relations exercise and it may lure consultants into an awkward corner. But, regardless of the 1975 award senior hospital doctors want a contract that ensures a fair reward for a tolerable work load. If consultant staff allow themselves to be outmanoeuvred now the prospects for all N.H.S. doctors—and, we believe, for the N.H.S.—will be bleak indeed.