and a control treatment group. This will not mask a drug effect in a treatment group but will permit a more precise estimate of the number of patients in whom the symptom is due to a particular drug.

How can the standardization of symptom reporting be achieved? In my opinion the doctor must not ask verbal questions but should devise a questionnaire which is completed by the patient. He must ensure that the written questions are understood by the patients, that the questions are completed, and that the questionnaire is returned by a high proportion of patients. Similarly, in a non-treated group the repeatability of the answers (positive or negative) should be tested.

Continuing the example above, a self-administered questionnaire found that 56% of patients on methyl dopa complained of sleepiness³ against 31% in the general population.⁴ By using such questionnaires the results should be reproducible and the side effects of new therapeutic agents (when evaluated by the same techniques) may be referred back to the known and validated control data.—I am, etc.,

C. J. BULPITT

Chronic Disease Control Study Unit,
London School of Hygiene and Tropical Medicine,
London W.C.1

¹ Amery, A., et al., *British Medical Journal*, 1970, 4, 392.

² Pritchard, B. N. C., et al., *British Medical Journal*, 1968, 1, 135.

³ Bulpitt, C. J., and Dollery, C. T., *British Medical Journal*, 1973, 3, 485.

⁴ Bulpitt, C. J., Dollery, C. T., and Carne, S., *Journal of Chronic Diseases*. In press.

SIR,—I would agree with Drs. E. C. Huskisson and J. A. Wojtulewski (29 June, p. 698) that the use of a check list of side effects during clinical trials biases both the observer and the patient. One use of a check list which they do not mention, however, is during the pre-trial assessment of the patients. It has been my custom for some years¹ to use a check list of common symptoms particularly relating to the gastrointestinal and nervous systems. These are recorded as being present frequently, occasionally, or never. I subsequently use a general question such as "Have the tablets upset you in any way?" and during the final analysis relate the answers to the pre-trial check list. This is of particular importance in trials in rheumatoid arthritis, where a period on placebo therapy may be considered unethical² so that the comparisons are between two active treatments with no untreated period available for enumeration of "placebo" side effects.—I am, etc.,

IAN HASLOCK

Rheumatology Unit,
Middlesbrough General Hospital,
Middlesbrough

¹ Haslock, D. I., Nicholson, P. A., and Wright, V., *Clinical Trials Journal*, 1971, 8, 43.

² Wright, V., *Rheumatology and Rehabilitation*, 1973, 12, Suppl., p. 54.

Vitamin E in Thalassaemia

SIR,—Your excellent leading article (22 June, p. 625) directs attention to vitamin E, this time as a possible aetiological factor in thalassaemia and other haemolytic states.

Since there are few drugs for which more extravagant claims have been made on flimsier grounds may we amplify some of your comments?

There is no doubt that vitamin E is a powerful antioxidant in vitro. There is no doubt that the susceptibility of red blood cells to autoxidation is much increased in thalassaemia major and in many other haemolytic states. It is uncertain whether in thalassaemia this is a cause or a consequence of the red cell abnormality. It is plausible but almost certainly untrue that it is in any way related to vitamin E deficiency. We have treated a number of children with thalassaemia with large doses of vitamin E for periods up to a year. We hope eventually to publish our findings in detail but our provisional conclusions can be briefly stated. It is comparatively simple in this condition to raise serum vitamin E levels to normal by oral medication. It is possible to reduce red cell malonyldialdehyde (MDA) (that is, the in-vitro susceptibility of the cells to autoxidation) to near normal. There is little to suggest that either change has any effect on the haemoglobin pattern or on blood transfusion requirements.

This is not perhaps altogether surprising in the light of recent experimental work. It has long been known that plasma is a powerful antioxidant, and its antioxidant potency can be measured.^{1,4} Fractionation has shown that vitamin E contributes only marginally to this activity, which is largely a function of two protein fractions. One fraction contains caeruloplasmin, and its mode of action is still uncertain. The second is transferrin, and its antioxidant potency is almost certainly a direct expression of its iron-binding capacity. The key role of iron and of iron binding in lipid autoxidation and antioxidant protection respectively points back to vitamin E as a possible diagnostic tool. Though, in our experience, the serum level of the vitamin bears no relation to the severity of the haemolysis it does seem to

correlate with the severity of the iron overloading.

Before discounting vitamin E as an aetiological factor in thalassaemia we would make two provisos. Firstly, though the increased susceptibility of thalassaemic red cells to autoxidation appears to be the result rather than the cause of the red cell abnormality this is not necessarily true of other haemolytic states. In particular the haemolytic thrombocytopenic syndrome of premature infants described by Oski and Barness⁵ and others almost certainly reflects oxidative damage. (It is also the only syndrome in man which can be attributed with reasonable certainty to vitamin E deficiency.) Secondly, the fact that vitamin E deficiency probably plays no causative role in thalassaemia does not mean that, given in pharmacological doses, the vitamin could have no beneficial action. In fact circumstantial and still very incomplete evidence suggests that it might mitigate the effects of iron overloading. The difficulty is that thalassaemia is an extremely heterogeneous disease and iron toxicity is particularly difficult to assess. One is, moreover, dealing with a drug which is being currently promoted for conditions ranging from varicose ulcers through loss of sexual vigour to cancer and old age. The answer clearly requires a carefully controlled—that is, long-term—and properly co-ordinated clinical or laboratory trial or both.—We are, etc.,

C. B. MODELL
J. STOCKS
T. L. DORMANDY

Department of Chemical Pathology,
Whittington Hospital,
London N.19

¹ Barber, A. A., *Archives of Biochemistry and Biophysics*, 1961, 92, 38.

² Vidlaková, M., et al., *Clinica Chimica Acta*, 1972, 36, 61.

³ Stocks, J., et al., *Clinical Science and Molecular Medicine*, 1974, 47, In press.

⁴ Stocks, J., et al., *Clinical Science and Molecular Medicine*, 1947, 47, In press.

⁵ Oski, F. A., and Barness, L. A., *Journal of Pediatrics*, 1967, 70, 211.

Community Medicine—a Disclaimer

SIR,—No doctor acquainted with the starved resources of so many departments of an average district general hospital can fail to sympathize with the cry from the heart of "Consultant Radiologist" exclaimed in his Personal View (6 July, p. 38).

What worries me is that his justifiable frustration is laid at the door of community medicine, particularly at this very time when its practitioners are engaged upon the task of endeavouring to demonstrate the true potential of injecting the preventive medicine concept into the whole of the Health Service and of strengthening the resources of the primary medical care teams—currently no less starved than the hospitals—to the better fulfilment of that greater part of medical care which will always fall to be undertaken outside the hospitals.

There are D.H.S.S. circulars which define subtle differences between the work of community physicians and specialists in community medicine, but the fact is that the term "specialist in community medicine" is a generic one, which for reasons of career and training embraces those medical administrators on the staff of regional health authorities who have to continue the un-

enviable task, formerly undertaken by senior medical officers on the staff of S.A.M.O.s, of dividing up the regional cake of medical manpower and resources between the understandable but currently unattainable desires of the clinical consultants.

Such work, albeit necessary, is scarcely representative of the essence of the emerging specialty of community medicine, which requires such careful nurture during its infancy. It is in no way to disown our hard-pressed colleagues holding such appointments to suggest to regional medical officers that the official description "specialist in community medicine" be tucked away in the personal files and that some more specifically descriptive title be adopted for day-to-day use.

Finally, one cannot let pass without disillusion "Consultant Radiologist's" vision of the specialist in community medicine enthroned at the apex of his vast managerial pyramid. Nothing could be further from the truth. Former medical officers of health who had built up carefully trained teams of medical and administrative staff, capable of fulfilling necessary services for the community, now find themselves naked, bereft,

and alone. The loss of, and dearth of recruitment of, public health and community medical officers has been a tragic loss to the public service. No less grievous has been the eclipse of the former chief administrative officers of public health departments. These irreparable losses of expertise represent a setback to the expectations of community medicine which will take many years to overcome.—I am, etc.,

KENNETH VICKERY
Community Physician

Eastbourne

Contraceptive Services

SIR,—Anyone reading Dr. M. V. Smith's letter (6 July, p. 46) stating that the Family Planning Association gave "wholehearted support for the decision to impose no age limit on supplies of contraceptives, following appropriate consultations," might be forgiven for believing that this "support" was the result of wide-ranging democratic discussion with F.P.A. clinic doctors who, along with nurses and lay workers, do the actual work. There was no such discussion. In fact, the first that clinic doctors knew about it was a public statement from the F.P.A.'s Executive in February 1973 calling for free contraceptives "irrespective of age." As chairman of a family planning doctors' group I protested at the time to the appropriate doctors' chairman on the F.P.A. Executive. I never had any satisfactory explanation and the F.P.A. continues to give the impression that an unqualified "no age limit" is acceptable to clinic professional staff.

Now that the Department of Health and Social Security and the F.P.A. have gone one step further and given "guidance" to doctors that the pill can be given to under 16s without parental knowledge, it is surely time that it was known that the much-vaunted democracy of the F.P.A. policy-making is a farce. Clinic doctors (who do the work) are only "advisers" in the F.P.A. and have a very small voice on committees—a voice that is easily (and often) ignored in such policy making. Luckily our contract still gives us clinical independence.—I am, etc.,

ELIZABETH ELLIOTT

Wisbech, Cambs

SIR,—I would like to take up Dr. M. V. Smith (6 July, p. 46) over his description of local health authorities who freely distribute contraceptives without imposing an age limit as "progressive and far-sighted."

"Progressive" they may be, for it is a term of doubtful merit—we all know examples of progress backwards. But "far-sighted"? Is it really far-sighted enough not to discourage young people who want sexual experience before marriage? I am aware of no objective research on this matter, but my impressions are that there are many older people who now deeply regret sexual experimentation in their youth; and I am inclined to believe that more stable marriages result between couples who were virgins before marriage. Certainly swapping of sexual partners before marriage often goes on to swapping after as well.

If this is so, surely it is more far-sighted—though much more difficult—to do everything we can to encourage young people to

remain chaste and self-controlled rather than to offer them contraceptives without warning.—I am, etc.,

W. G. BENSON

Kennford, Exeter

SIR,—Closure of the debate on the Annual Report of Council under "Family Planning" (A.R.M. 2, para 13) at the Annual Representative Meeting in Hull prevented me from voicing what I feel must have been in the minds of many Representatives at the meeting that it is insufficient for the report to state the doctor's responsibility for the physical and mental care of our patients, however willing or otherwise they may be to participate in an all-embracing advisory service on contraception, without issuing a warning to society at large that the consequences of permissiveness, in the young in particular, could endanger the preservation of the family unit as the basis of all civilized society and run the risk of uncontrollable disease in the future. Either or both of these consequences could imperil survival of a sound social structure and I feel we would be failing in our duty as doctors if we remained silent on so important a matter.

The Times of Friday 12 July reported that a girl of 12 had given birth to a son in West Hill Hospital, Dartford, Kent, and that mother and child were doing well. One is tempted to amend this statement to read that both children were doing well and point out the distressing and worrying background, known to doctors and social workers in innumerable similar cases. A moment's thought would, I think, convince all those concerned with the future welfare of this country that further thought should be given to sex education, the degree of irresponsibility of the young to the jeopardy of their future, and the resulting undoubted acute misery in human relationships, the consequences of which must be the concern of doctors, educationalists, and politicians alike.—I am, etc.,

BERNARD HALFPENNY

Maidstone

"Market Research" on Private Practice

SIR,—I was approached today by an organization calling itself the Specialist Research Unit asking me to give them an interview. I established that they were in fact a market research organization and I gave the inevitable groan expecting that I was to be queried why I prescribed brand X rather than brand Y and wouldn't it be better if I used new brand Z. However, it appeared I was required to give an hour of my time so that my attitudes to private practice could be evaluated. The area manager of the firm would not (or could not) disclose the name of their client.

In view of the present political climate I declined the interview as I believe that the attitudes of the profession at this moment should not be available to sources which might quite easily use such information to the profession's detriment.

I write to you in order to warn my colleagues that they may unwittingly agree to such an interview without being aware of its nature.—I am, etc.,

M. J. OLDROYD

Birstall,
Batley, Yorks

Democracy in the Health Service

SIR,—*"Democracy in the Health Service"* is the self-assertive title given by the Secretary of State for Social Services in the Labour Government to a paper published recently.¹ It criticizes the National Health Service Reorganization Act 1973 for being bureaucratic, appointive, and undemocratic in that it "deliberately separates responsibility for managing the Health Service from responsibility for representing the views of the public as the consumer." This, it says, "is to challenge in a fundamental way the essence of democratic control."

The Government's proposals centre primarily on giving greater power to local authority councillors. The paper states that at least half of the nominees of the community health councils to the area health authorities should be local authority councillors and that one-third of the members of regional and area health authorities should be drawn from local government. Furthermore, R.H.A.s are encouraged to attach weight to prior service on C.H.C.s when making appointments to A.H.A.s. Despite all this deliberate inbreeding, the document in a moment of supreme naivety states that "all members of health authorities should participate fully and objectively. . . . It will not be their responsibility to represent local authority, staff or Community Health Council interests."

The following points occur to me.

(1) Community health councils would become yet another arena for party political warfare. The prize of membership of a health authority would be up for grabs, local authority nominations to C.H.C.s (half the membership) would be in the patronage of the majority party, and in time even the other half of the membership, made up from voluntary organization nominees and R.H.A. appointees, might develop an increasingly party political complexion. To active party politicians this might seem to be a good thing and indeed they might question whether health and welfare could ever be other than party political issues. Seen from the other side, however, I wonder how many people who are actively working in health and welfare, or giving help in some form, would consider themselves to be active party politicians. It seems a pity that those who do not should be shouldered away.

(2) Party politicians will remain party politicians whatever authority they serve on, otherwise their prospects for re-election by their own party, let alone by the public, would be bleak indeed. Thus all authorities will become increasingly party political and the situation in health will resemble that in education. In the prevailing two-party system some authorities will chop and change their plans according to whichever local government is in power and other authorities will have their plans chopped and changed for them according to whichever national government is in power.

(3) In time the medical and nursing professions will be outnumbered on the various authorities by previous or current local authority councillors and others with party political loyalties. Then the true purpose of Mrs. Castle's paper will have been achieved—the professions will at last be ensnared; they will have the trappings of representation but in practice will be the servants of the ruling political party, who alone, in the