and the efforts of vocational training schemes to increase the skills of young doctors in this area.

Dr Aldridge cites much anecdotal evidence in support of his views. However, most caring doctors will use any agency to supplement their own care in appropriate circumstances and Dr Aldridge should recognize that some doctors and some patients find his approach intrusive and unhelpful in a doctor–patient relationship which has often been nurtured over many years.

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Serum theophylline concentrations in general practice patients

Sir,

Dr Howard concludes in his paper (March *Journal,* p.105) that less than 25% of general practice patients were achieving a theophylline concentration in the therapeutic range. As Napp Laboratories are the manufacturers of Phyllocontin Continus tablets which were taken by the majority of patients in Dr Howard's study I would like to make the following comments.

Of the 34 patients taking Phyllocontin Continus, 26 were taking one tablet (225 mg) twice daily, one patient took one at night and one patient took one tablet three times a day. We have for some years now tried to persuade general practitioners to prescribe two tablets twice daily as a maintenance dose. However, general practitioners might not be at fault. Dr Howard did not quote an original source in his justification but Mitenko and Ogilvie[1] showed that the dose–response relationship was a log relationship. Thus bronchodilation can be seen at 27.5 μM or even lower.[1] However, even in a patient with little or no reversibility, theophylline can improve lung function although it is not demonstrable by the traditional parameters of peak flow and forced expired volume.

We have recently sponsored a trial of controlled-release theophylline in irreversible airways obstruction but in addition to measuring peak expiratory flow rate and the forced expired volume in one second which measures large airways, we also measured trapped gas volume, slow vital capacity as well as six-minute walking distance. A validated computer predictor programme was used to optimize dosage in each patient — the programme establishes pharmacokinetic variables from a single blood sample, and optimum theophylline levels by means of Bayesian analysis. We looked at all outcome measures at serum theophylline levels of 0, 6.3 (± 0.37), 12.1 (± 0.33) and 18.3 (± 0.52) $\mu g\ l^{-1}$ (or 0, 34.6, 66.6, 100.6 μM).

A dose–response relationship was observed for trapped gas volume, slow vital capacity and six-minute walking distance even at the lowest theophylline dose. It is especially noticeable that the trapped gas volume fell by 22.8%, 42.9% and 63.6% respectively for the three doses. The forced expired volume and peak flow only showed statistically significant differences at the highest level of theophylline.

This demonstrates that theophylline has an effect on smaller airways whose calibre is not measured by peak flow or forced expired volume. The fact that this effect was correlated to a dose–response effect in increased walking distance is remarkable evidence of the value of smaller airways dilation in chronic bronchitics. Thus, the therapeutic window which is readily accepted is probably too narrow in terms of effects on larger airways and is certainly so in terms of smaller airways.

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Antibiotics in acute otitis media

Sir,

I would like to comment on recent studies of the use of antibiotics in children with acute otitis media. In the interests of epidemiological purity, the patients' symptoms seem to have been overlooked. Several studies[1-4] support the notion that antibiotics may not influence the short or long term sequelae of otitis media and that the condition is self-limiting and relatively benign. Do antibiotics help relieve the pain and discomfort acutely? Diamont,[1] in his study of the effect of withholding antibiotics at the first encounter with patients with otitis media, only mentions pain briefly. Van Buchem[2] tried to estimate pain levels in children with otitis media but the use of a mixture of analgesics, sedatives and nose drops spoilt the results. In a later paper[3] he describes how an 'estimated' 4860 children with otitis media were treated with analgesics and nose drops for three to four days before being divided into severe and less severe groups. Only 10% were deemed severe on the basis of continuing symptoms such as pain. No mention was made of the discomfort experienced in the first three days nor were the side effects of the nose drops mentioned. The impression was given that severe pain resolved more quickly with antibiotics than with myringotomy alone but the numbers involved were small.

Hopefully the current research mentioned by Bain[5] will help to answer the remaining questions about otitis media. Until then many of us will continue to prescribe antibiotics at the first encounter with a child who has otitis media in the belief that pain relief will be faster and perforation may be avoided.

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Ethics and the pharmaceutical industry

Sir,

Dr Wall's paper (June *Journal,* p.267) has turned the debate on the relationship between doctors and drug firms back to general practitioners once again. I believe an awkward relationship has been helped only a little by the guidelines that have been suggested.

Drug companies exist to make the maximum profit for their shareholders and it is a secondary matter that this profit is made out of products designed to lessen human suffering. All advertising and promotion influence those who receive it — £160 million is being spent on promoting drugs to general practitioners[1] and to consider ourselves immune from its influence is naive.

We are the servants of the public and we are spending their money on the drugs we prescribe. It is essential that our judgement as to what is in the best interests of a patient is unimpaired by promotional

activities. The Royal College of Physician's report[2] concludes that any benefit in cash or kind must leave the doctors' independence of judgement unimpaired. I cannot see how any benefit can fail to impair the judgement: 'a bribe blinds those who see and twists the words of the righteous' (Exodus 23:8).

Our consulting rooms are adorned with more advertising logos than Nigel Mansell's car. In the room in which I am writing I can see 16, and this is typical. What message is being communicated to patients who, to quote Dr Wall, 'expect doctors' conduct in prescribing and investigating drug actions to be above criticism'? I think we all need to examine our actions regarding our relationship with the pharmaceutical industry. I have thrown away the demeaning gifts I have accepted in the past and as a practice we are making no new appointments to see drug representatives.

As a College member I should like to see a list of the drug firms that have donated money to the College published regularly. Are the activities they sponsor essential and why does my £115 annual membership fee not cover them? Why cannot the *Journal* be free of all drug advertisements?

I realize that drug companies 'do not like dealing in an unseemly trade of ballpoint pens and Italian red wine — they want to make their case and be off'.[1] At present all promotional material addressed to me ends up unopened in the waste bin but if any drug company would care to send me a scientific paper supporting a product of theirs I promise to read it. Does anyone want to join me in choosing this way of being influenced?

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Sir,

The three articles on ethical dilemmas between doctors and the pharmaceutical industry (June *Journal*, pp. 267, 270, 271) do not mention the free supply of patient leaflets and record cards by drug companies. Are these considered as bribes?

We need patient leaflets with health education information and instructions on the use of medications. Many such publications are provided by the Health Education Authority and by self-help organizations for certain diseases; a few are home-produced by local hospital departments. But there are gaps in common and important topics which are currently filled by drug company productions, many of which are extremely good and non-promotional, although they all need careful vetting.

General practice record cards for contraception and shared care, such as diabetes, can also be obtained from drug companies when they are not provided by the Department of Health and Social Security. The alternative is to buy cards from the Royal College of General Practitioners or to design and produce them oneself.

The change from the Health Education Council to the Health Education Authority, with more central government autonomy, has led to further restriction of the range of DHSS funded publications, so who should pay for the rest? Should we ask for reimbursement for dispensing literature to patients?

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An ethical committee for general practice

Sir,

It is with interest that we read the paper by Drs Sullivan and Barber (August *Journal*, p.365) describing the proposals received in the first year of an ethical committee for general practice. Their experience in the West of Scotland is similar to our own, although we have found reluctance from one or two pharmaceutical firms to make the changes suggested to them. We are surprised that their ethical committee is of an unbalanced composition. While eight general practitioners and one lay member may be able to make a scientific decision relating to ethical matters, we doubt if they can give a comprehensive ethical opinion without the inclusion of members from other disciplines. The Royal College of Physicians and the BMA give firm guidelines on the composition of ethical committees and we would strongly suggest that any general practitioners considering setting up ethical committees should do so only on the suggested guidelines.

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Healthcall and the College

Sir,

Dr Kinnersley (August *Journal*, p.371) correctly states that the College has signed an agreement giving endorsement and approval to Healthcall, a medical information service for patients, and this was reported to members of the College in the June issue of the *Journal*.

Both the Royal College of General Practitioners and the College of Health are interested in providing good information to patients. However, when the College of Health extended its programme through a number of districts it did not consult the Royal College of General Practitioners and did not seek general practitioner advice about the information being given to patients. Our College believes that it is extremely important that patients should have the best possible advice and that general practitioners are particularly well placed to provide it.

Therefore, when the opportunity arose to enter into an agreement which would provide advice for patients, we welcomed it believing that general practitioners as a body and the College as an organization can make a substantial contribution to this work.

Patients now have a greater choice of information and are quite free to use whatever service they feel is better suited for their needs. Nobody is obliged to pay the commercial charges but the fact that over three million calls have already been made to this service suggest that it is meeting a need.

Since the College was negotiating with a commercial organization, we saw no reason why commercial rates should not be paid to the College. The money accruing from this source will of course be used to further the aims of the College.

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Patients' opinions on the services provided by a general practice

Sir,

In my paper on patients' opinions of general practice services[1] I said that I was unable to compare my results with those of Cartwright and Anderson[2] because they expressed their results in percentages rather than numbers. It has since been pointed out to me that the number of people involved is always quoted at the bot-