until the patient recovers by himself, is cured, dies, or is referred for a second opinion. The GP learns to make decisions quickly and most of them, in most practices, are right.

We could not escape a reference to deputising services. Dr Davies implies that the public is being duped into accepting an inferior service and then, in the next sentence, suggests approvingly that some patients may prefer the emergency locum to their own doctor. This confused attitude makes me think of a squash player trying to play forehand and backhand at the same time. Perhaps an excess of spleen has clouded Dr Davies's thinking. Very few people can talk calmly about deputising services. Some GPs, usually those who work in a large rota, regard their use as betraying shameful weakness. Others welcome them as saviours of their users' health and sanity. Newspaper columnists and politicians make great play of the deputy's having done a day's work in hospital before he comes on duty. Nobody in my recollection has ever complained that the family doctor on call for his practice has also done a full day's work and will do another tomorrow.

Further on the family doctor is told to "join the 20th century and return to the practice of medicine as we understand it today." If he has never been there how can he return to it? Who are "we"? Whose is the concept that family doctors are replacing the clergy as problem solvers and soothers? *Do* family doctors want to replace the clergy? In what school of alchemy did Dr Davies learn that catalysts act on one another? What does the Isis Centre have to do with the case? Why is there a change of person in the third paragraph under "primary medical care"—is it an example of the well-known conjugation, "I plan, you do, he is an idle slob"?

Dr Davies's plans for the future are a logical extension of his imperfect apprehension of the present. GPs, whatever they are called, have enough to do without taking on, unpaid, the work of miniconsultants. Specialisation in general practice has been tried and found unsatisfactory for doctors and patients.[1] If I have a hernia I want the man who repairs (not "corrects") it to be a competent surgeon, not a dilettante who will scream and turn pale if he uncovers something unexpected and nasty. Like most family doctors I diagnose, investigate, and treat not only the hypertensives and the subthyroids but the thyrotoxics, maturity-onset diabetics, congestive cardiac failures, and sufferers from a host of other diseases.

There are bad hospitals, bad consultants, and bad GPs; there are fellows, readers, and research associates who work in ivory towers and, filled with the confidence born of ignorance, utter vapid bletherings. But it would be unfair, misleading, and scientifically reprehensible to generalise from the particular.

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[1] Spence, J C, *British Medical Journal*, 1975, **1**, 390.

SIR,—Dr T F Davies (4 December, p 1376) refers to "two standards of care in the hospital service: the teaching centres and the rest" and he repeatedly uses that misleading and thoroughly objectionable term "centre of excellence."

I have worked in four of his "centres" and in four peripheral hospitals and I truly believe that, for all but rare and bizarre conditions, the quality of care, both medical and nursing, is as good in the latter. The attempt to produce factual evidence for his statements is remarkably naive from a research associate in medicine. Hospital mortality is a poor index of quality of care in myocardial infarction, and in any case the results of five of the non-teaching hospitals are as good as, or in three cases better than, those of his two teaching hospitals.

Of all the letters Sir Alec Merrison will receive few will be as arrogantly misleading as the one you have just published.

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Defence against bacterial drug resistance

SIR,—In his excellent review (16 October, p 933) Professor L P Garrod discusses the advisability of restricting the local application of antibiotics. He points out that it is important to preserve bacterial sensitivity to gentamicin and compliments the manufacturers of this antibiotic for not making a preparation in tablet form. However, we are rather worried about the use of the topical preparation of this compound and its potential for promoting resistance.

We have recently seen an outbreak of gentamicin-resistant staphyloccocal infection involving 23 patients in a dermatology unit which seemed to be associated with a high usage of topical gentamicin. The total amount of this preparation used in the hospital was 15 804 15-g units in 1974-5 and 23 020 15-g units in 1975-6, of which the pharmacy estimated over 90% were used in the dermatology unit. Our findings are to be published in detail elsewhere.[1] At the beginning of the outbreak the use of topical gentamicin was severely restricted and the number of patients involved then fell dramatically (see table). As can also be seen from the table the number of new patients with gentamicin-resistant staphylococci has since remained at a low level. The reason for the continuing isolations from new patients is obscure, but resistant organisms seem capable of surviving in lesions for extended periods—six and nine months respectively in two patients with varicose ulcers.

Isolations of gentamicin-resistant staphylococci

Month	No of new patients involved
December 1975	3
January 1976	1
February 1976	6
March 1976	15*
April 1976	3
May 1976	1
June 1976	1
July 1976	0
August 1976	2
September 1976	5†
October 1976	6‡

*Restriction of topical gentamicin usage.
†Includes two patients not directly associated with Belfast City Hospital.
‡Includes three patients not directly associated with Belfast City Hospital.

An unfortunate recent trend is the isolation of gentamicin-resistant organisms both from patients in other hospitals and from patients of general practitioners (see table). Perhaps this trend is not surprising since in Northern Ireland 117 528 15-g units of topical gentamicin preparations were prescribed by general practitioners in a typical four-month period, October 1975-January 1976 (source: Chief Pharmacist, DHSS, for Northern Ireland).

We certainly agree with Professor Garrod's statement that "a decision to apply gentamicin cream should not be taken lightly" and hope that his words will be heeded and will lead to a much reduced usage of these preparations.

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[1] Wyatt, T, *et al*, *Journal of Antimicrobial Chemotherapy*. In press.

Paroxysmal brain stem dysfunction in multiple sclerosis

SIR,—We agree with the need to be aware of the possibility that paroxysmal disturbances may be the first manifestation of multiple sclerosis (MS), as in the patient reported by Drs W H Perks and R G Lascelles (13 November, p 1175), but their statement that such paroxysmal brain stem disturbances have not previously been reported as the sole presenting feature of MS is not correct. Several of the references given by McAlpine *et al*[1] in their section on short-lived and paroxysmal attacks include case reports in which such symptoms preceded other evidence of MS. In six of our 32 patients[2] with paroxysmal disturbances originating in the brain stem or spinal cord these were the initial manifestations of MS. In a more recent report of different types of paroxysmal attacks in 22 patients with MS[3] there were at least four in whom paroxysmal brain stem disturbances were the first symptom of MS.

We believe that such paroxysmal disturbances occur as the first manifestation of MS more commonly than is generally realised. They should be distinguished from transient ischaemic attacks as the paroxysmal disturbances of MS usually occur in a younger age group, tend to be of briefer duration, recur more frequently, and respond to carbamazepine.[1] It is important to recognise them not only because of the rewarding response to carbamazepine but also in anticipation of the day when effective treatment given early may prevent the irreversible stages of the disease.

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[1] McAlpine, D, Lumsden, C E, and Acheson, E D, *Multiple Sclerosis—A Re-appraisal*, 2nd edn, pp 185-190 and 252. Edinburgh, Livingstone, 1972.
[2] Espir, M L E, and Millac, P, *Journal of Neurology, Neurosurgery and Psychiatry*, 1970, **33**, 528.
[3] Osterman, P O, and Westerberg, C-E, *Brain*, 1975, **98**, 189.

Penicillin-insensitive pneumococci

SIR,—I wish to correct some misconceptions regarding pneumococci with diminished sensitivity to penicillin. Professor L P Garrod writes (16 October, p 933): "Resistant strains [of pneumococci] were first encountered in New Guinea where penicillin was being used in a seemingly not very satisfactory way for the prevention of pneumonia, to which the inhabitants are said to be peculiarly subject for climatic reasons. Two others were then detected in Australia, and later others have been reported in North America, and one