

considered in the differential diagnosis of acute severe chest pain in young fit adults.

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1 Henry JA. Ecstasy and the dance of death. *BMJ* 1992;305:5-6. (4 July.)

EDITOR.—John A Henry's editorial¹ and Ibrahim H Fahal and colleagues' drug point² highlight a growing medical problem arising from the recreational misuse of ecstasy (3,4-methylenedioxymethamphetamine or MDMA). For each relatively rare and major complication of ecstasy, however, we suspect that many lesser events will go unrecorded. These will take their silent toll of the people concerned and consume valuable resources in medical institutions.

Two young men were brought to the accident and emergency department at this hospital by ambulance. The first was aged 18 and had suffered a fit after taking ecstasy. He admitted to having had a fit one month earlier, also after misuse of ecstasy. Examination showed a sinus tachycardia but no other abnormality. He discharged himself from casualty. The second patient collapsed after complaining of a headache and was carried in on a stretcher. We suspected that he had had a fit, but no eye witnesses accompanied him. He was drowsy but scored 15 on the Glasgow coma scale. He had a tachycardia and both biochemical and electrocardiographic evidence of hyperkalaemia. He was given activated charcoal and admitted for overnight observation. On discharge the next morning he stated that his experience would not stop him using ecstasy again.

We suspect that many acute hospitals throughout the country could relate similar stories. Although reports of chronic psychosis and acute rhabdomyolysis associated with misuse of ecstasy give cause for concern, we believe that the main burden for hospital and ambulance services will be the more mundane and often unreported effects of acute intoxication.

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1 Henry JA. Ecstasy and the dance of death. *BMJ* 1992;305:5-6. (4 July.)
2 Fahal IF, Sallomi DF, Yaqoob M, Bell GM. Acute renal failure after ecstasy. *BMJ* 1992;305:29. (4 July.)

EDITOR.—In his otherwise comprehensive editorial on the medical complications of using ecstasy, or 3,4-methylenedioxymethamphetamine (MDMA), John A Henry omits cerebrovascular disease.¹ Sympathomimetics are widely recognised causes of both cerebral infarction and haemorrhage.² We have reported four cases of spontaneous intracerebral haemorrhage related to ingestion of ecstasy or amphetamine.³ The patients were aged 16-30, and two had consumed ecstasy inadvertently in spiked drinks. Three patients presented with hemiparesis and one in coma. Cerebral angiography was performed in all four. Three had normal intracranial vessels and made good functional recoveries. The other, whose computed tomogram showed a considerably larger

haematoma, had an arteriovenous malformation and died.

Drug misuse should be considered in young patients presenting with stroke, and serum and urine should be screened for ecstasy and amphetamine if indicated. We agree wholeheartedly that the popular belief that ecstasy is a safe recreational drug is erroneous.

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Service increment for teaching and research

EDITOR.—The editorial and two papers examining the allocation of the service increment for teaching and research were not sufficiently critical of what was a pragmatic solution to an unrelated problem.^{1,3} The introduction of the Resource Allocation Working Party formula in the mid-1970s, which allocated on the basis of need rather than historic costs, threatened the privileged position of the teaching hospitals, which had previously received 14% of revenue with only 6% of beds.⁴ Legitimised by some questionable statistical work,^{5,6} the service increment for teaching helped to paper over the fact that the large hospitals, especially those based in London, were too expensive by attributing much of their excess costs to teaching.

The situation of the expensive teaching hospitals was further exposed by the NHS reforms, which link hospitals' revenue much more closely with services delivered and average prices. This prompted the inclusion of a research component in the service increment for teaching and a flurry of work on ways to allocate it, sometimes resulting in perverse incentives.

The King's study, for example, weights the number of student full time equivalents per speciality by the costs of that speciality over and above costs in non-teaching hospitals.⁷ This makes the untenable assumption that all excess costs are directly proportional to teaching. It is then tautological to show an association between excess prices and the service increment for teaching offset so calculated. More worrying is that the same number of students will attract different amounts of money depending on the excess costs of the speciality. This underwrites inefficiency and, because it ignores the actual teaching input, creates no incentive to teach the students allocated, let alone teach them well.

The Leicester study, which used students' diaries, found considerable variation in teaching input.⁸ It is being repeated with quality measures added. Universities should take advantage of this opportunity to exert more control over hospital based teaching, ensuring the quality of the teaching and learning environment rather than spending time developing sophisticated techniques for allocating a crudely calculated sum.

As health care in London is rationalised and more students are taught in "non-teaching" hospitals, where they can get a broader and more humane experience, so the current arrangements will come under greater critical scrutiny. A more efficient approach is needed whereby students are taught in the cheaper centres (while quality is ensured) rather than money being allocated to the more expensive ones.⁹ Accredited hospitals and

health centres should be able to bid for the opportunity to teach students as part of a clear syllabus, with a realistically calculated service increment for teaching as an explicit payment.

Surely the time has come to recognise that the service increment for teaching was a post hoc rationalisation for expensive service delivery generally unrelated to teaching. Where this expense is justified ways to fund it explicitly should be sought; where it is not justified this hidden subsidy should be replaced by improvements in efficiency.

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2 Black GB, Bevan G, Peters TJ, Eddleston ALWF. King's model for allocating service increment for teaching and research (SIFTR). *BMJ* 1992;305:95-6. (11 July.)
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EDITOR.—C L Smith states that "sufficient detail of the attributable costs [under the service increment for teaching and research] can be derived to allow for accountability and justification of use."¹ The figures given in the paper do not seem to support this. Costs derived from the survey that Smith quotes, and about which we are given no details, account for only 35% of the service increment for teaching and research allocated. Virtually no evidence is offered in support of the contention that costs related to infrastructure account for 70% of the total allocation.

There is a basic difficulty in that we know what the difference in cost between teaching and non-teaching hospitals is but not what it should be. Drawing conclusions about revenue costs from differences in use of space is problematic: buildings represent only a small proportion of the cost of health services, and space is unlikely to be a good indicator of the costs of activity. It may well be true, as Smith argues, that the true costs are greater than the funding, but on the evidence offered this remains unproved.

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1 Smith CL. Service increment for teaching and research (SIFTR): the Southampton experience. *BMJ* 1992;305:97-8. (11 July.)

Coronary vasospasm and sumatriptan

EDITOR.—B H C Stricker presents data on 12 Dutch patients who experienced chest symptoms, variously described as anginal pain, substernal pressure and discomfort, heaviness, and tightness.¹ It seems that electrocardiograms were obtained in only three patients and were normal.

We do not believe that these cases can legitimately be described as similar to the case reported