Our cases also illustrate the inadequacy of conventional radiography in assessing the sternoclavicular joint. Tomography and scanning techniques provide more useful information and were instrumental in reaching the correct diagnosis.

Several different bacteria may be implicated, and a wide variety of organisms have been reported in previous series, including *Pseudomonas* in heroin addicts. *Str milleri*, however, has not been reported. An association with sternoclavicular joint sepsis and diabetes has also been noted,[3] and one of our patients was diabetic and the other two receiving steroids, which may have contributed to their susceptibility to the infection.

Sternoclavicular joint sepsis must be included in the differential diagnosis of atypical upper anterior chest pain. A wide variety of organisms may be implicated, the signs may be minimal, and conventional radiographs are often unhelpful. Tomography and scintigraphy are helpful, and joint aspiration to isolate the causative organism is necessary to make the diagnosis.

We thank Professor A E Read for permission to report on his patients, and Dr Iain Watt for his help.

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Letter from . . . Chicago

Burning up the files

GEORGE DUNEA

From time to time the files used in preparing these letters grow so bulky, bulging with reprints and countless other scraps of paper, that the only solution is to take whole folders and throw them in the fire. They give but little heat, but at least they make the living room look a little less like the famous library of Alexandria.

A prime candidate for such unceremonious treatment is the collection on compulsory postdoctoral education. Not that doctors would be expected to be anything but perpetual students. But sometime in the mid-'seventies, as I noted earlier (29 July 1978),[1] the process of learning was formalised, apparently to satisfy consumer demand and fend off the threat of periodic relicensure by examination. Within a few years many states legislated arrangements by which doctors would receive credits for going to lectures. Relicensure would be conditional on the doctors certifying that they had satisfied the prescribed requirements; and the licensing departments, like the Internal Revenue Service, were to conduct random audits to make sure that nobody had cheated and cut classes.

These arrangements proved to be an immense success. Within a short time they gave rise to a profitable industry, with a potential market of some $2 billion a year. Everybody set up continuing education programmes, the hospitals, the schools, the medical societies, and soon more than 20 000 courses became available, ranging from brief local meetings to luxury cruises abroad. According to reports some institutions earned up to $50 000 from three-day seminars attended by 500 doctors. Enterprising faculty members were always on the road with their slides; and the profits trickled down to travel agencies, cruise organisers, audio and video tape manufacturers, and producers of computer software.

Not surprisingly, this compulsory commercialised instruction was viewed with disgust by many members of the profession. But then these were the difficult consumerist antidoctor days of the early 'seventies, when it was widely predicted that within 10 years periodic recertification would be a reality. "The public is demanding more accountability from the doctors," was the wisdom of the time; and everybody seemed resigned to the fact that the era of lifetime licensing was over and that the profession had lost control of the education of its members. It was also noted that what had begun as a voluntary educational programme leading to no more than a plaque on the wall had been seized on by hospitals, medical societies, and eventually the licensing bodies, and made into a mandatory requirement. Some doctors wrote irate articles about stamping out compulsory education. Others composed clever Socratic dialogues about the meaning of different types of credits. But most doctors fell into line, so that it became a matter of course to sign in at conferences and then file away the certificates for the unlikely possibility of an audit.

Probably nobody was really hurt by compulsory education. Indeed, many more lived on it. It became just another formality, like saving receipts for the income tax. But this year something unexpected happened in Springfield, in the last wild days of the Illinois legislature, when all the bills that had lain dormant in committee suddenly emerge on the floor so that even the legislators cannot keep up with what is going on. Bills abolishing continuing education as a requirement for licensure were introduced in both houses. They passed. A multimillion industry may have been irreparably harmed—at least in this state. Some professors may have to stay home. Some continuing education experts may become unemployed or will need to be retrained for other jobs. And I will take a chance

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and throw out the whole file, though conscious of the risk that some accrediting body may still save the day by finding a reason why we should go on saving credits to show that we are keeping up to date.

Files on institutions

I wish I could as confidently discard my files on municipal hospitals, county jails, or nursing homes for the aged, institutions which no local taxpayer really wants but which refuse to go away. So that every few years a crisis comes up, then an indignant exposé in the newspapers, then a general catharsis with calls for reform and an end to the appalling conditions, perhaps leading to a new law, some new regulations, the sending of a few inspectors, the setting up of a commission, and then back to business as usual. For the municipal hospitals, at least in Chicago, there has been no trouble for some time, though the recent influx of the new medically indigent from the stressed private hospitals provides good prospects for future difficulties. As for the jails, the state is running out of money, the tiers are overcrowded, and there is constant talk of squeezing more people into the cells, building more prisons, letting criminals out on parole, or having work release programmes. But for the nursing homes the problem becomes more incurable each year as the number of the aged and the infirm increases; and everybody agrees that they deserve good care except that nobody wants to come up with money. This summer the outburst of indignation in Chicago was triggered by a prolonged heatwave during which four patients, mostly over 80 years old, died in sweltering rooms in which the air conditioners were not working.

Television showed the nursing home being evacuated, then reporters disclosed that the owners had not fixed up the air conditioners because it cost $15 000 and described how slimy green algae covered the cooling tower and clogged the pipes. The local authorities closed the institution. The medical examiner described the deaths as homicide. Legislators proposed bills providing for more inspections; and the newspapers emphasised the need to protect these most vulnerable members of society. But in the same week the city announced it was laying off more workers to narrow the budget deficit, hence the inadvisability of disposing of the nursing home file.

Files on new drugs

One file, however, that could at least be thinned out in the confidence that it will soon fill up again is that on the problems of introducing new drugs into the United States. Not that things have not improved with repeated criticism and the advent of an antiregulatory administration, so that the much touted drug lag may have been largely overcome as new antibiotics, antihypertensives, and anxiolytics are coming on the market in growing numbers. Yet problems remain. Important drugs are still waiting to be released; and there is a growing perception that regulatory policies are killing the golden goose and that drug innovation is declining sharply. At a time when it takes 12 years and costs $70 million to bring a new drug on the market, we are reminded that the new drugs (and vaccines) are responsible for most of the decline in mortality since the end of the second world war.[2] Yet during the frequent polemics on pricing, profits, monopolies, patents, and side effects, it is overlooked that over 90% of all new drugs are discovered by industry—and that nobody else has the tools to undertake their development. This process now takes place in an adversative and hostile environment, there is an obsession with safety, and prohibition of discovery has become the normal state of affairs.[2] As initiative is discouraged and creativity suppressed, there will be fewer unexpected discoveries and no more serendipitous observations leading to new cures.[2] It has often been said that digoxin would never have been approved by the regulators, nor would aspirin, even before the excitement about a link to Reye's syndrome. Nor would Edward Jenner have been allowed to experiment on the Phipps lad, though he might have been advised to try to see if cattle would develop smallpox after exposure to infected children, and he probably would have lost his licence or at least his grant.[3] As the development of new drugs is being stymied by delays and demands for proof of safety, investing in new products is becoming increasingly unprofitable and risky.

In recent years the Food and Drug Administration, under the leadership of the now departing commissioner Arthur Hayes, has promised to expedite the process by which drugs are evaluated. It has also taken a firm stand and scrapped a consumer programme that would have forced manufacturers to distribute warning leaflets together with some of the more frequently prescribed drugs. But also, quite reasonably, and probably with the support of most doctors, it has taken a stand against direct advertising of prescription drugs to the public—a doubtful practice that raises the spectre of doctors being swamped with patients requesting the latest drug advertised on television. The drug lobby may also be disappointed by the recent unwillingness of Congress to extend the lifetime of patents for drugs to more than the present 17 years. But at least there is hope that new regulations will shortly reduce the time needed to approve new drugs.

Standards and procedures

The final issue concerns the efforts of the Joint Commission on Accreditation of Hospitals[4] (see letter of 20 March 1982) to update its manual on standards and procedures. Last December, apparently prompted by fears of antitrust litigation, the board, dominated by commissioners representing the American Medical and Hospital Associations, voted to change the wording of its rules on the composition of hospital executive staff committees, so that "organised medical staff" now read "organised staff." There was considerable opposition from the American Colleges of Surgeons and Physicians (the other members of the commission) and from the medical profession at large to a change that potentially could have allowed the medical executive staffs to be dominated by non-medical persons. In February the American College of Surgeons issued a strongly worded statement deploring the prospect of "unsupervised care of patients in the hospitals (being) provided by persons not fully qualified," emphasising that fully licensed physicians should have the ultimate responsibility for care. For several months the dispute simmered, then the trustees of the American Medical Association backed down and presented its delegates at the annual meeting with a "compromise plan."

The new wording restored the old arrangements, though apparently accepting a possible role for "limited licence practitioners" who are qualified and approved by the executive medical staff. Final ratification by the commission should allow the consignment to the flames of an unnecessarily bulky file, whose final destruction we view in the same spirit as Julius Caesar regarded the burning of the library at Alexandria. "What is burning is the memory of mankind" had suggested Theodotus, Cleopatra's tutor. "A shameful memory. Let it burn," retorted Caesar. But as an alternative we note that the books not consumed by fire were distributed some 700 years later by order of the caliph to the city's public baths, leading a famous historian to comment that it was ultimately still to the greater benefit of mankind.

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