At a time when ways of successfully sharing jobs—successful for the employer, the employees, and the patients—have been tried and tested and when society's attitudes towards sharing parental responsibility for child care are changing this document is, at best, anachronistic. We suggest that formal consideration of part time training should be an integral part of such planning documents.

GRAHAM BICKLER LESLEY MORRISON
SIÂN GRIFFITHS LUISE PARSONS
CARMEL MARTIN TOM ROHAN

Department of Community Medicine,
City and Hackney District Health Authority,
London N1 5LZ

1 Burns C. Part-time training in community medicine. *Community Medicine* 1986;8:138-41.

SIR,—In the 16 August issue of the *BMJ* there are no fewer than 36 advertisements from locum agencies. A recent communication from one of these states that last year the locum agency achieved a tenfold increase in the number of hours worked through the agency.

When one compares the disparity between NHS locum rates and those paid to agencies, it is clear that a very large amount of NHS revenue is being diverted to this profitable form of private enterprise. If the "safety net" proposed by the working party on manpower were to include a staffing structure which would provide for holiday and study leave cover by staff in post there would be revenue savings, improved job prospects, and probable improvement in patient care and continuity.

E R WILLIAMS

George Eliot Hospital,
Nuneaton CV10 7DJ

SIR,—The implications of the letter from Mr J H Peters (16 August, p 449) about the establishment of a subconsultant grade are unclear. He appears to imply that those in a subconsultant grade must be subservient, in contrast to the views of the previous correspondent, Mr M C T Morrison (p 449). Is he further implying that the only doctors who are highly qualified and intelligent but in subservient employment are refugee doctors and married women, thus highlighting the exploitation of these doctors in the present organisation of medical manpower? Alternatively, perhaps he means that instead of the highly qualified, intelligent, and subservient doctors with whom he would like to people a subconsultant grade, all he will find available are refugee doctors and married women. If this is his contention then his statement insults both these groups. His reference to pin money, pin being "something small or of very little value," may be an apt description of the remuneration but not of the skilled services that most of these doctors provide.

JENNIFER DENNIS

Park Hospital for Children,
Oxford OX3 7LQ

SIR,—Dr H A F Mackay (30 August, p 565) states that the most able medical graduates are now opting for and having to compete for places on GP vocational training schemes because they perceive the opportunities available to practise a high standard of medical care in the community. I agree that community medical care is of a high standard but disagree with the reasons he gives for junior doctors choosing general practice.

I have worked with many junior hospital doctors in my seven years in the United Kingdom. Many excellent medical graduates choose a career in

general practice, many no doubt because they have always wanted to be GPs. An equal number have made this decision because during their clinical training they have seen able senior registrars "stuck" with a very long wait before getting a consultant post, if they ever do. They are able and bright enough to decide that a career in hospital medicine is the most difficult to achieve, is totally unpredictable, and necessitates moving all over the country for suitable training posts with no guarantee or choice in where they will eventually get a permanent post. Yes they are able—able to see the writing on the wall because of the shortages of career training posts and consultant posts in the NHS. They know that a GP training scheme offers guaranteed employment for three years and that then they have a chance of a permanent post. They also know that potential earnings in three years' time will be greater than if they stay in hospital medicine. These are the reasons they have given me for their choice, but possibly not those given to Dr Mackay at interviews.

Mr Tom Coffey (30 August, p 567) highlights the problems as the medical students see it—the future for these medical students is far from rosy. Ten years ago as a medical student I assumed (correctly as it turned out) that I could be a consultant or whatever else I wished to be—the choice was mine. I gave it no great consideration and chose a general medical training post and then made my choice three years after graduation—naïve and very foolish by today's standards. Now the students I meet have eliminated more than half the possibilities by the end of their first clinical year.

Young doctors now choose their careers with one thing in mind—to be employable. They cannot afford the luxury of what they would be best at or what they would enjoy the most. I think Dr Mackay is out of touch with the real views and concerns of junior doctors in Britain. Mr Coffey, president of the students' union, knows the real situation.

HELENA M DALY

Department of Haematology,
Royal Cornwall Hospital (Treliske),
Truro

SIR,—The "window of opportunity" presented by the simultaneous tenure of office of the two deputy chairmen of the Joint Consultants Committee and the former Minister of State for Health is now closed. The timing of publication of the proposals outlined in *Hospital Medical Staffing—Achieving a Balance* and their rapid endorsement at urgently convened meetings of the Central Committee for Hospital Medical Services and the Hospital Junior Staff Committee indicate a desire to seize the package on offer and ensure its immediate implementation without modification.

The time—albeit short—has come for more mature consideration. Unfortunately, irrespective of the merits of the proposals, hospital doctors are not in a position to make informed comment in the absence of the following factual information: the number of regional registrars in the acute specialties; the number of consultants eligible for early retirement and their specialties (this option is not available on demand); and the terms and conditions of service of the new intermediate level service grade (which is junior to the associate specialist grade).

Nevertheless, certain observations on the package are desirable. Firstly, figures from the Department of Health and Social Security show an increase of three general surgical posts in the five year period 1980-5.¹ Such a record does not inspire confidence in consultant expansion. Secondly, partial retirement is an existing option. Thirdly, district registrars and the new intermediate level

service grade are subconsultant grades in all but name. They lack career prospects and appear to be discriminatory against overseas doctors and those with domestic commitments. There will be few willing applicants. Fourthly, the proposed maximal increase in numbers of senior house officers does not match the reduction in registrar numbers. Where is the "safety net"? Finally, the suggestion that doctors seeking experience in research should normally acquire this before entering the registrar grade poses a real threat to the standard of medical education.

The group has failed to address the root cause of manpower imbalance—namely, medical school intake. The proposals do not provide the basis of a credible and realistic career structure. Furthermore, it is difficult to envisage how implementation of the package as a whole, without modification, can improve the level of patient care.

R K GREENWOOD

Leicester Clinic,
Leicester LE5 1HY

1 Department of Health and Social Security. Medical and dental staffing prospects in the NHS in England and Wales. (Table 2.) *Health Trends* 1986;3:49-56.

Disclosure of diagnosis of acquired immune deficiency syndrome

SIR,—A London general practitioner was recently dealing with a patient suffering from the acquired immune deficiency syndrome who was extremely aggressive and needed urgent transfer. He therefore called in the local police to help but on the grounds of confidentiality failed to inform the officers of the diagnosis, and they were therefore put at considerable risk. In fact, the BMA statement on the acquired immune deficiency syndrome makes it quite clear that the diagnosis may be made known to other people if there is a risk of spread of infection, as in this case.¹ I am writing to you in the hope that this letter may draw attention to the existence of this helpful document and thus prevent further episodes where police are put at risk, both in London and nationally, in this way.

E C A BOTT

Metropolitan Police,
London SW1

1 Board of Science and Education, British Medical Association. *Statement on acquired immune deficiency syndrome (AIDS): report.* London, BMA, 1986.

Angina pectoris-like pain provoked by intravenous infusion of adenosine

SIR,—Dr Christer Sylven and colleagues (26 July, p 227) presented a study of six volunteers who developed chest pain after intravenous injection of adenosine. As this angina-like pain was abolished by concomitant injection of the adenosine receptor antagonist theophylline the authors concluded that adenosine receptors play a part in anginal pain induced by hypoxia in patients with coronary heart disease and suggested, furthermore, that an adenosine release might serve as a "warning signal" during myocardial hypoxia. There are two points that should be commented on.

Adenosine increases coronary blood flow¹ and prolongs atrioventricular conduction.² Both effects are mediated by two different subtypes of adenosine receptors on the outer surface of the cell membrane—that is, by so called A₁ and A₂ receptors.³ In patients with coronary heart disease dipyridamole is well known to produce a coronary steal phenomenon and hence can induce angina pectoris. As dipyridamole blocks the uptake

of adenosine into the cell⁴ the concentration of adenosine at the external adenosine receptors (A₂) is increased, leading to an augmentation of the vasodilatory effect of adenosine in intact coronary arteries. This situation, capable of producing a coronary steal phenomenon, is similar to the enhancement of the extracellular adenosine concentration by intravenous injection of adenosine. Therefore it is not unreasonable to suggest that intravenous bolus injection of adenosine produces a transient coronary steal phenomenon, leading to chest pain in the six volunteers studied. As theophylline is also an antagonist at coronary A₂ receptors⁵ the amelioration of chest pain by concomitant injection of this methylxanthine supports this view. The conclusion drawn by the authors that adenosine receptors have a role in mediating pain therefore appears somewhat premature.

Furthermore, intravenous injection of adenosine has been used to terminate paroxysmal supra-ventricular tachycardias in patients.^{6,7} In these studies only facial flushing was recorded as an adverse effect. As a reasonable number of patients (certainly more than 100) have been treated with similar doses of adenosine without chest pain a study on six patients is probably not sufficient to present a new clinically relevant aspect on the therapeutic use of adenosine.

M BÖHM
E ERDMANN

Klinikum Großhadern,
8000 München 70,
West Germany

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Low concentrations of formaldehyde in bronchial asthma

SIR,—Dr H Harving and colleagues (2 August, p 310) exposed 15 asthmatic patients to low concentrations of formaldehyde fumes and found no significant changes physiologically or in the symptoms of asthma. They concluded that concentrations of formaldehyde found in the indoor environment were of minor importance in the development of pulmonary symptoms.

While I agree that asthmatics are usually not affected by formaldehyde, I think they should have been more positive about the importance of occupational asthma due to formaldehyde, which is a rare but distinct entity. They quote the work of Burge and colleagues¹ but say only that such reports of occupational asthma "claimed" that it was due to hypersensitivity. In fact, occupational asthma due to formaldehyde has been recognised for almost 50 years² and is well documented.

Burge and colleagues actually described three "classic" examples and drew particular attention to the characteristic late asthmatic reactions that followed exposure at work and were also a feature of the subsequent positive bronchial provocation tests. The patients whom Dr Harving tested had

not been working with formaldehyde and were therefore not eligible for hypersensitivity to the gas. Even asthmatics who work with formaldehyde are rarely affected by it, as shown by Nordman and colleagues,³ who found only 12 examples of "specific sensitisation to formaldehyde" among 230 asthmatics working with formaldehyde.

Cases of formaldehyde asthma have been reported not only from industry but also from hospitals, where formaldehyde is used for preserving pathological specimens and sterilising instruments.^{4,7} I hope that the Industrial Injuries Advisory Council, which recently increased from seven to 14 its list of "agents at work that cause asthma for which disablement benefit is payable" (23 August, p 513), will soon add formaldehyde to the list and give official recognition to those few unfortunate individuals who have been forced to give up their professions early or retire prematurely because of formaldehyde induced asthma.

BRIAN E HEARD

Department of Lung Pathology,
The Cardiothoracic Institute, and
Brompton Hospital,
London SW3 6HP

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Risk factors for uterine fibroids

SIR,—The study by R K Ross and others (9 August, p 359) indicated that the risk of uterine fibromyomas decreased with increasing number of term pregnancies, longer oral contraceptive use, and cigarette smoking and was positively related with body weight. Since these risk factors are similar to those for endometrial cancer the authors speculated that women with endometrial cancer might have an increased prevalence of fibromyomas.

We analysed the relation between history of uterine fibromyomas and the risk of endometrial cancer using information from a case-control study conducted in Milan in 1979-80. The data shown in the table, derived from a 1982 study,¹ indicate that patients with endometrial cancer reported more frequently a history of uterine fibromyomas, with a relative risk of 3.0 (95% confidence interval 1.8 to 5.1).

This estimate is possibly inflated by detection or recall bias since patients with endometrial cancer are particularly sensitised towards uterine complaints. None the less, the magnitude of the increased risk supports the hypothesis that uterine

Distribution of 173 patients with endometrial cancer and 347 controls according to history of uterine fibromyomas¹

History of fibromyomas	Endometrial cancer	Controls	Relative risk (95% CI)*
No	130	313	1†
Yes	43	32	3.0 (1.8 to 5.1)
Unknown	—	2	

CI=Confidence interval.

*Adjusted for body weight and oestrogen use. †Reference category.

fibromyomas and cancer of the corpus uteri have common aetiological mechanisms, possibly mediated through increased oestrogen availability.

CARLO LA VECCHIA

Istituto "Mario Negri,"
Milan,
Italy

FABIO PARAZZINI
ADRIANO DECARLI

Istituto Biometria,
University of Milan,
Italy

SILVIA FRANCESCHI

Contro Riferimento Oncologico,
Aviano (Pordenone),
Italy

1 La Vecchia C, Franceschi S, Gallus G, *et al.* Oestrogens and obesity as risk factors for endometrial cancer in Italy. *Int J Epidemiol* 1982;11:120-6.

Role of general practitioners in treating opiate misuse

SIR,—Mr Alan Glanz (30 August, p 543) suggests that general practitioners are loth to get involved in the care of drug misusers. While I cannot argue with the results of his questionnaire, I would seek to put a slightly different emphasis on the result. I would suggest that general practitioners' reluctance to deal with drug misusers often stems from the fact that we are responsible for the patients' total health rather than able to specialise in their particular problem of drug misuse.

Perhaps I may illustrate this by a patient of mine who, at the age of 43, suffered a severe myocardial infarction; while he was recovering from this his wife died, leaving him with three small children. He developed angina and because of the family situation was rushed into hospital as soon as he developed chest pain. In order to try and prevent these frequent admissions he was given regular injections of opiates when he had the angina, and this led to his becoming habituated to this drug. The problem in his management was that we were responsible for his cardiac condition as well as his misuse of opiates. We were also under pressure from the casualty department to cut down on the number of admissions to hospital, and from the ambulance service to reduce the number of calls via 999. While this may sound like a sob story to justify the way in which we managed him, I suggest that it illustrates the problems of being on call day and night with patients having the right to telephone us and ask for help 365 days a year. The hospital drug unit has the advantage of having to deal with only the drug problem, and any medical problem that may arise can be dealt with separately by the general practitioner.

One further problem faced in present day general practice is that the use of rotas and deputising services makes it difficult to have a coordinated approach to drug misusers.

T BILLINGTON

Lordshill Health Centre,
Southampton SO1 8HY

Is inexperience a defence against negligence?

SIR,—Reading Clare Dyer's article (23 August, p 497), I notice that in none of the judgments she quotes is reference made to the junior doctor's ability to recognise when he is out of his depth. She quotes Lord Justice Glidewell as arguing that the law required the trainee or learner to be judged by the same standard as his more experienced colleagues, and that inexperience could be argued as a