hospitals and those working in conventional psychiatric hospitals.

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¹ Quinn, S, *Nursing Times*, 1979, 75, 237.

Falciparum malaria despite chemoprophylaxis

SIR,—Mr P Moody rightly points out the great current difficulty involved in the selection of optimal malaria prophylactics for some parts of the world (9 June, p 1565) and shows the disadvantages of almost all the options available.

His view that advice may be difficult to obtain is, however, fortunately less correct. The Ross Institute of the London School of Hygiene and Tropical Medicine (01-636 8636) is happy to provide such advice on malaria prophylactics to both doctors and the general public, and does provide it to many thousands of people each year; while the Liverpool School of Tropical Medicine, the Hospital for Tropical Diseases in London, and the East Birmingham Hospital all provide similar advice.

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Multiple-puncture tuberculin testing

SIR,—We have been considerably interested in the articles and correspondence on this subject, because we screen approximately 500 new employees in the NHS hospitals in the Ipswich health district and we found it convenient to use the tine test. Unfortunately our experience of a marked BCG reaction after negative tine readings led us to review this procedure.

Traditionally, Heaf testing had been used for many years. We found that when employees with negative tine reactions were tested by this method a significant proportion gave a grade 2 reaction, and BCG was unjustified. Two years ago therefore we discontinued the use of tine testing. As we were looking for people needing protection the procedure for us was too unreliable. We can summarise our experience as being "a positive tine test is reliable, but don't trust a negative one."

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Contaminated hospital water supplies

SIR,—The reports (3 February, p 350) and letter about contaminated water supplies (9 June, p 1564) drew attention to a potential hazard that fortunately manifests itself but rarely.

At present, "wholesomeness" is the accepted requirement applicable to all water supplied for human consumption, whether from the public supply or commercially bottled. The term does not imply sterility but indicates that the water complies with the standard.¹

Members of the *Pseudomonas* group do not usually survive the normal methods of water treatment as applied at water works, but they

may gain access to the distribution system in small numbers subsequently. If these organisms reach a site where nutrients are available, which may often be the result of using unsuitable plumbing materials, then multiplication is possible. Raising the water temperature will, within limits, encourage multiplication of certain bacteria, including *Pseudomonas aeruginosa*. Increasing the water temperature to the 50–60°C range will largely overcome this problem. The use of the correct plumbing materials and recommended water temperature will be effective only if the roof tanks are in a good state of repair and properly covered.

The National Water Council publishes a list of plumbing items which have been constructed from materials that will not support microbial growth.

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¹ Joint report from the Department of Health and Social Security, the Welsh Office, and the Department of the Environment, *Public Health and Medical Subjects, No 71*. "Bacteriological Examination of Water Supplies." 4th edn 1969, reprinted 1974, London, HMSO.

Review Body report

SIR,—I suppose we should be grateful for the recent award by our Review Body but in the area of general practice it has been palliative rather than remedial. There is a sad lacking of any long-term policy and planning that might have been so easily able to improve standards of practice generally. The following areas come specifically to mind.

A greater increase in the basic practice allowance would have encouraged practices to increase partnership size. By this means more jobs would have been created, and a decrease in the patient-doctor ratio would improve medical standards. A greatly increased fee for performance of cervical cytology would have offset the heavy losses made by most practices performing this service voluntarily on the under-35-year-olds, again improving medical standards.

Finally, the awards for the out-of-hours payments are still derisory. The toil and bane of general practice lies for most doctors in their out-of-hours responsibility. Where deputising services are available they are expensive and where the GP is forced to cover himself the cost to mind and body can be destructive. Once again the Review Body has failed to recognise and reward this very great responsibility. After-hours calls in general practice (and this should mean after 6 pm) can never be paid at less than a recall fee for a hospital consultant.

The Review Body has more than a duty simply to prevent doctors from resigning en masse: it could be used as an intelligent tool to improve medicine. This time, as ever, it has failed.

A R ROGERS

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Pay and contracts

SIR,—In my retirement, I sympathise deeply with those who struggle to obtain acceptable contracts for the work of doctors and nurses. The provision of a service that is free for all seems to involve some loss of appreciation by

the public, and also to lessen the incentives which helped us in the past to give of our very best.

However, we must also bear in mind that in the present state of worsening chaos in many parts of the world it seems quite ludicrous that Western nations should keep struggling to improve their already high standard of living, and there is a universal need to encourage and admire those who adopt a simple pattern of living. For us to be members of an interesting profession is rewarding in itself, so that we might at least consider the possibility of setting the much-needed example of a group that is willing to accept somewhat less than we are entitled to demand. We must try to discourage the competitive lunacy which is so damaging to today's world.

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Domesticated doctors

SIR,—I read with some annoyance the letter from Dr Ruth E Ferguson about the so-called domesticated doctors (16 June, p 1632).

Women doctors have a choice these days and she has made hers. Many of us have opted for the half-way house, which involves "neglecting our families" for a minimum of 20 hours a week. We married women doctors cannot have everything handed on a plate. If a woman doctor wants to be involved in medicine then she herself must make a considerable effort both at work and at home. If she is prepared to do this then the RHA and the postgraduate dean will help her with her training. We must make sacrifices, go to meetings, take postgraduate examinations, and practise medicine actively (even if only part time). Otherwise we will not be taken seriously as professional women.

Most of us thoroughly enjoy our double life and hope that we are making a small contribution to the running of the NHS now, and will be doing more in the future when we have fewer domestic commitments.

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The general practitioners' work load

SIR,—I was disturbed to hear of the Review Body's rejection of the professions' claim that work load has increased, particularly when I read that the Review Body quoted a reduction in the number of prescriptions issued as one of the indications of a falling work load.

As a dispensing practitioner who has made a particular effort over the last few years to reduce my prescribing of medicines, I can assert that a fall in the number of prescriptions issued results in a considerable increase in the general practitioners' consultation time and hence work load. If we are to give more time to counselling our patients, then the outcome should be a fall in prescriptions issued.

It seems that the Review Body's misinterpretation of a statistic may have cost general practitioners dearly. It is all the more unjust since a fall in the numbers of prescriptions issued not only represents a great saving to NHS funds but I believe is very much better for our patients. Indeed, the recent LMC