Dr Lutton's concluding advice to me about my medical care would have been impertinent if it had not been completely irrelevant. The general views expressed in his letter would perhaps have carried more weight if he had not chosen to invent a rift between myself and my doctor in his anxiety to emphasise the gulf he believes to exist between general practitioners and hospital consultants.

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How to use an overhead projector

SIR,—In his letter (9 June, p 165) on my article on the use of the overhead projector (3 March, p 602), Dr J Robbins commented on the use of a Xerox machine or a similar copier to produce projectable transparencies from books, drawings, tables, or electrocardiograms in a matter of seconds. There is one great drawback in carrying out this procedure and this is that the amount of material which goes on to the transparencies is too great and when projected almost impossible for an audience to read.

The point I made in the original article about the number of lines on a transparency and the number of words in a line cannot be emphasised enough: nothing is more irritating to an audience than being unable to read the message on the visual aid.

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Extradural haematoma: effect of delayed treatment

SIR,—Mr G M Teasdale and Mr S Galbraith (30 June, p 1593) have commented on our paper regarding the management of extradural haematoma (12 May, p 1240), where we emphasised that delay in evacuating an extradural haematoma in a patient who is deteriorating is dangerous.

The dangers of delay in this situation must be considered separately from the politics of deciding on which admission policy should be applied to neurosurgical units. All neurosurgeons must agree that an extradural haematoma should be evacuated as rapidly as possible in patients who deteriorate. We would like to stress the importance of avoiding any factors which might increase these delay times. In most hospitals to which such patients are primarily admitted immediate access to computerised axial tomography (CAT) is impossible. Over-zealous attempts to transfer deteriorating patients for this or any other investigation will increase the mortality and, more important, the morbidity of survivors with this condition. Even the delay of half an hour in a case of straightforward extradural haematoma in order to obtain a CAT scan when it is available is unpardonable. We made this quite clear in our paper.

We agree that pure extradural haematomas represent a small minority of head injuries, but it is a group that should do well unless there is associated brain damage of severity. In 1977 in seven patients our mortality was zero. It is precisely because of its rarity that the extradural haematoma is often overlooked.

We therefore make no apology for stressing the need for immediate surgical exploration and evacuation of clot in this small group of head injuries.

The problem of admitting only those patients to neurosurgical units who are referred is that the vital decision of *when to refer* usually has to be taken by those who are relatively unfamiliar with the complex problems of the complications of head injuries—that is, the district hospital surgeon and his junior staff. Neurosurgeons cannot handle all head injuries but they can provide a centre of excellence for head and spinal injuries with undergraduate teaching and postgraduate training of general and accident and emergency surgeons. They can also provide a round-the-clock telephone consultation service followed up by flying squad assistance when there is the slightest doubt in the mind of the referring surgeon if the patient cannot be transferred, and he has begun operative evacuation of clot in the outside hospital. This has been the policy for hospitals outwith Edinburgh since 1952, and will continue to constitute the 50% not handled in the department of surgical neurology. Most of those with head injuries occurring in the city are admitted direct to the neurosurgeons.

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Tap water instead of electrode jelly for electrocardiographic recording

SIR,—We have read with interest the article by Dr Ann Martin and others (17 February, p 454). In this study ECG recordings using tap water were as good as those using electrode jelly.

At the Vasa Hospital, a geriatric, long-term care hospital, we have carried out a similar study. On 30 consecutive inpatients where ECG recording was indicated, recordings were taken using first tap water and then electrode jelly. The recordings were made on the wards, with the patients in their beds, using Elema-Schönder 34 equipment with repeated-use metal electrodes. The ECG recordings were analysed by one of us (OD), who did not know which type of technique had been used, and the recordings were classified into the following categories: good or satisfactory, slight interference, heavy interference. An evaluation was also made to see if the recording with jelly was better than the one with tap water or vice versa, or if they were equivalent.

The only interferences that were observed were alternating current interference. The table shows the resulting quality of the ECGs.

Comparison of tap water and electrode jelly used for electrocardiographic (ECG) recording

Quality of ECG	Jelly	Tap water
Good or satisfactory	9	5
Slight interference	18	15
Heavy interference	3	10

χ^2 -test: $0.10 > 2p > 0.05$

The quality was the same with jelly as with water in 15 cases, but the jelly was better in 14 cases, whereas the tap water was better in only one case.

Thus in our study electrode jelly was much

superior to tap water for ECG recording. Possible explanations for the difference are different surroundings during the ECG recordings (in our study all ECGs were taken on the wards), differences in the recording equipment as well as differences in the types of electrodes used.

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Fifty years of penicillin

SIR,—After reading the leading article "Fifty years of penicillin" (28 April, p 1101) I feel that being one of the first patients to receive penicillin in large quantities (several million units) I have much reason to thank Professors Flemming and Florey for their wonderful discovery, work, and persistence against almost impossible odds.

During the period I spent in the RAF hospital at Whitchurch, Shropshire, and St Hughes at Oxford 1943-4 being treated for osteomyelitis of the skull, the first penicillin treatment I received was penicillin in a sulphide base, dusted on to gauze and packed into the wound. On my transfer to St Hughes, while undergoing a number of operations to remove the affected bone penicillin was given intravenously and intramuscularly. At first it was only possible to dissolve 1000 units in one pint of saline; after a few months, and when the American penicillin became available, it was possible to dissolve 10 000 units in one pint, and later 100 000 units.

At the start of the second front, when penicillin was still in short supply, and I was under observation and requiring regular dressings, I assisted in reclaiming penicillin from the urine of patients receiving heavy doses and had the exceptional privilege, for a few months, of working under Professors Flemming and Florey.

In conclusion, I would like to say that although the surgical skill and treatment I received was the highest one could ask, I am convinced that penicillin was a very large factor in my being able to record the above today.

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Care of low-birth-weight babies

SIR,—Your leading article "The therapeutic pendulum and the special care baby unit" (3 March, p 575) considered the thorny question of how extensively the facilities of special care baby units should be used.

In the rural ex-mission hospitals of Transkei such units do not exist, yet two years' experience in different hospitals here has left me with the strong impression, shared by my colleagues, that low-birth-weight babies do very well despite the absence of elaborate facilities. To test this belief, I studied the records of this hospital's maternity department for 1978. During the year 113 live-born infants weighing 2500 g or less were born, and there were five deaths (44.3 per 1000 live births). Of 36 live-born infants weighing

2000 g or less, four died (111.1 per 1000). These figures compare favourably with those for England and Wales for 1974 quoted in the article. Yet they were achieved with only two incubators and devoted care from hard-pressed nurses and, especially, the mothers—they invariably remain in hospital, breast-feeding, until their babies are ready for discharge.

On the other side of the coin, of six live-born infants weighing 1500 g or less, three died; and in this group the benefits of intensive care may be more evident. But I venture to suggest that the results achieved with slightly larger babies with minimum facilities might give food for thought to those who would transfer from the parents to technology the care of increasing numbers of low-birth-weight babies.

I thank Dr C L Bikitsha, Secretary for Health and Welfare, Transkei, for permission to submit this report for publication.

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Review Body's award and consultant contract

SIR,—I would be grateful for the opportunity to clarify, for all consultants, the precise situation regarding the Review Body's award on the existing contract. Following helpful discussions with the Secretary of State, immediate steps are being taken to implement the 18% salary increase and I have already agreed with DHSS the advance letter to health authorities instructing them to pay consultants the appropriate amount, backdated to 1 April. I am hopeful that most authorities will be able to pay this by the end of August.

The Secretary of State has accepted on behalf of the Government that the 8% applied by the DDRB to emergency recall fees should be transferred to the basic salary in accordance with the decision taken by CCHMS at its emergency meeting on 14 June. A joint approach by the Government and the professions will now be made to the Review Body to confirm this arrangement. Such action should not take unduly long and I would expect this additional 8%, backdated to 1 April, to reach consultants at the end of October.

I hope that these comments will clarify the situation, which has been somewhat confused as a result of the circular to all consultants issued by our colleagues in the Hospital Consultants and Specialists Association. However, I trust that this letter will not affect the opinions of any consultants who may wish to draw the attention of the Secretary of State to my incompetence, as suggested in the HCSA circular.

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New consultant contract: the shelf or the bin?

SIR,—Two hearty cheers for the Review Body, which has spelt out the ineluctable facts of life. Even if they had not extracted part of our basic salary to pay for emergency recall fees this time, it would have happened next year or the year after, when it was too late to renounce the

new contract. Even in its prime that contract tottered unsteadily on two supports: a pay policy that rigidly constrained basic salary and a hope that we could circumvent the policy by fiddling with overtime, like many of our fellow citizens. Both supports have crumbled but some seem anxious to pickle it in aspic and store it on the shelf. Many an unlikely lad or lass has come down off that shelf to the tinkle of wedding bells so I am alarmed at the prospect of this legless wonder one day emerging from its pot to harass us again.

Our negotiators face a tougher task than ever and they need the wholehearted support of the profession, not the lukewarm approval of the majority and the outright opposition of a substantial minority that the new contract evoked. I believe they would command that support more readily if they renounced the new contract altogether and gave it a decent burial forthwith. I hope they will go further and admit that the whole idea of a work-sensitive contract for consultants is nonsense. The junior staff contract is sensitive to nominal time on call but quite insensitive to real work. As soon as it appeared, departments which had never printed a duty roster since 1948 suddenly discovered them in the bottom drawer and piled on the units of medical time. I do not blame them: if we wanted to preserve radiology, pathology, etc, they had to compete with the financial attraction of clinical specialties that were already oversubscribed. If this happened with junior staff, who are under the control of their seniors, what would have happened when consultants started writing their own job descriptions? I know there are hard-pressed orthopaedic and ENT surgeons who have no colleague for 100 miles and who must take everything that comes, but the only heat on most of us is created by our own exertions.

The urgent task is to ensure that that 8% is restored to basic salary in lieu of emergency recall fees. Thereafter we need a package deal that nearly everyone can support. It must be a nice balance of advantage between part-timers and full-timers. Part-timers have one big legitimate gripe: they must drop 2/11ths of their salary for the privilege of doing private work even if they do it in their own free time. Full-timers have an equally legitimate gripe and an understandable fear: they have none of the tax advantages which are the main attraction of private medicine and they are afraid that high earnings by part-timers will be taken into account when the basic NHS salary is fixed.

I suggest that there would be widespread support for the following package provided it was negotiated as one deal. Maximum part-time salary to be 10/11ths for those who genuinely do planned private work outside normal working hours and whose private on-call commitment within normal working hours is small. No account of private earnings to be taken when NHS salary is negotiated; all mention of spare-time earnings (medical and other) to be excluded from evidence given by DHSS to Review Body. Mileage rate for out-of-hours calls and regular user's allowance to be acknowledged as genuine expenses entailed on behalf of NHS and therefore non-taxable. Stupid restrictions on out-of-hours calls (must be called by house physician, etc) to be removed. Regular user's allowance to be distributed more generously to those who have a real but small business mileage. All such improvements in reimbursement or tax allowance to be made simple and free of the

necessity to keep meticulous records of small sums.

An inexpensive poll of one in ten of the profession, if well designed, would tell our negotiators whether the new contract should remain in suspended animation or not and whether such a package could command the 80% support I believe they need.

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Emergency recall fees and basic salary increase

SIR,—We note from Linkman Letter No 8 that the CCHMS has decided to ask the Secretary of State to stop payments of emergency recall fees and distribute the money to all consultants as an 8% increase in basic salary. There is no reason why this 8% increase should not be negotiated separately and perhaps the CCHMS should more properly direct its attention in that direction and to having emergency recall fees made a pensionable element of income.

Now that at last a financial reward is available for those consultants who frequently work during the evening and night, we are not keen to give some of it away to those who don't. Simple justice suggests that if emergency recall fees are to go into an equally divided pool, the total money paid for family planning and domiciliary fees should be shared out equally in the same way.

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A body to review not criticise?

SIR,—At a recent study day on the report on the Normansfield problems it seemed clear that a great many clinicians associate good facilities and at least adequate staff as more important than any new monitoring which might be devised.

During the general question time Dr Peter Sykes, a consultant psychiatrist, described working in Scotland, where one was pleased to have a visit from a small body whose objective was not criticism but review of the basic conditions in which one practised. Such a body would be welcomed, I have little doubt, particularly where its recommendations would compel an area or regional health authority to act to correct deficiencies within its responsibilities.

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Ethics, strikes, and the GMC

SIR,—Professor John A Davis's letter (23 June, p 1712) must not go unchallenged. I cannot accept that the General Medical Council should specifically outlaw mass withdrawal of labour in disputes over pay and conditions. Withdrawal from the NHS, particularly in the current conditions, must