from each patient were typed at the Cross-infection Reference Laboratory, Colindale, by bacteriocin sensitivity, by flagellar and somatic serology, and by bacteriophage. The strains were indistinguishable by these methods. The organism was sensitive to amikacin, nalidixic acid, and trimethoprim (except in one patient who previously had been treated with co-trimoxazole) and was resistant to gentamicin (minimum inhibitory concentration 10 mg/l), ampicillin, carbenicillin, chloramphenicol, cephalosporins, colistin, kanamycin, mecillinam, nitrofurantoin, sulphonamides, tetracyclines, and tobramycin.

Environmental investigation has failed to reveal the source of the organism and there is no evidence of intestinal carriage in patients or staff. The hands of medical and nursing staff in the unit were examined on several occasions using a glove washing technique¹ followed by filtration of the washings through membrane filters and incubation on cystine-lactose electrolyte-deficient (CLED) medium² overnight. This showed that the hands of one nurse who was noted to have a mild paronychia were heavily colonised with *S. marcescens*, and direct swabbing of the paronychia showed that this was infected. The strain, which was indistinguishable from those isolated from patients, could still be isolated from her hands after washing with soap and water but was cleared temporarily by using a spirit-chlorhexidine-glycerine lotion.³ The organism was not found on the hands of other members of the staff. As the paronychia improved direct swabbing of the site sometimes failed to show the organism when its presence was evident by the hand washing technique, showing the latter to be more sensitive.

At the time of writing there have been no new cases of infection in the intensive care unit and we hope that the removal of the carrier has brought the incident there to an end. So far as we know this is the first time such a resistant strain of *S. marcescens* has infected several related patients in the UK.

We are grateful to Mr T L Pitt for typing the strains.

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¹ Casewell, M, and Phillips, I, *British Medical Journal*, 1977, 2, 1315.

² Mackey, J P, and Sandys, G H, *British Medical Journal*, 1966, 1, 1173.

³ Lowbury, E J L, Lilly, H A, and Ayliffe, G A J, *British Medical Journal*, 1974, 4, 369.

Oxytocin and neonatal jaundice

SIR,—Drs Mary N Smith and R G Wilson (7 January, p 50) associate oxytocin with neonatal jaundice. An association there is, but it is probably not a cause-and-effect relationship. Our work in Winchester¹ has shown that the babies of women induced for "post-maturity" have a lesser incidence of jaundice than do those of women who go into labour spontaneously. Women induced for obstetric indications (and therefore frequently preterm) have babies who are more prone to become jaundiced. The implication is that it is prematurity and not oxytocin that is the important factor causing jaundice in babies born after induction of labour. The differences between our work and that of others is that we used

ultrasound to determine a patient's estimated date of delivery rather than her "dates."

Every obstetrician knows that labour is sometimes induced more early than intended because the "dates" are misleading. Obviously if labour is induced prematurely it is more likely that oxytocin in high dosages will be necessary to effect delivery—hence much of the confusion that surrounds this debate.

A D NOBLE

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¹ Williams, T H, *et al*, *Lancet*, 1977, 2, 1169.

Biguanides and lactic acidosis in diabetics

SIR,—I agree with the statement in your leading article (3 December, p 1436) that both phenformin and metformin predispose to lactic acidosis, but metformin seems less dangerous. We have calculated that the risk of lactic acidosis with phenformin may be 50 times that with metformin.¹ Metformin's relative safety may reflect its lesser effects on lactate metabolism,^{2,3} its lack of effect on renal acid excretion,⁴ or its different pharmacokinetics.

Although cases of metformin-associated lactic acidosis are rare and often reported more than once, we have seen one and have reviewed the 23 other cases in the literature.⁵ Two striking features emerged. Firstly, renal impairment was common. Sixteen of the 18 documented patients had renal impairment, nine were anuric (six following radiographic contrast studies), and six of the anuric patients had continued their metformin. Secondly, in the 23 documented cases other conditions which predispose to lactic acidosis often existed (cardiovascular disease in 11, liver disease in three). One other patient had taken a suicidal overdose. Although lactic acidosis can occur with metformin, the risk should be small if the drug is prescribed to patients who do not have impaired renal, hepatic, or cardiovascular function.

P J PHILLIPS

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S Australia

¹ Phillips, P J, Thomas, D W, and Harding, P E, *British Medical Journal*, 1977, 1, 234.

² Phillips, P J, *et al*, *Australian and New Zealand Journal of Medicine*, 1974, 6, 174.

³ Phillips, P J, and Edwards, J B, in *Proceedings of 1Xth Congress of International Diabetes Federation*, Amsterdam, Excerpta Medica, 1976.

⁴ Phillips, P J, *et al*, *Proceedings of the Endocrine Society of Australia*, 1977, 20, 71.

⁵ Phillips, P J, Scicchitano, R, and Clarkson, A R, *Australian and New Zealand Journal of Medicine*. In press.

Appointment at Luton and Dunstable

SIR,—There recently appeared in the *BMJ* (14 January, p xli) an advertisement requesting applications for the post of "consultant surgeon with special experience in urology . . . with duties mainly at the Luton and Dunstable Hospital."

Long before the present holder of this position was due to retire we discussed among ourselves and with the administration the exact nature of the work of his successor. It was agreed that when the post came to be advertised it would be for a urologist with the

proviso that the successful applicant would be expected to take part in a one-in-four duty rota for general surgical emergencies.

We, general surgeons at the Luton and Dunstable Hospital, are taking the unusual step of writing to you in the hope of avoiding frustration and disappointment for any of our colleagues who may apply for the position.

W M MEE

R V FIDDIAN

R L ROTHWELL-JACKSON

Luton and Dunstable Hospital,
Luton, Beds

The Steve Biko inquest

SIR,—In response to Professor R Hoffenberg's letter (14 January, p 112) I would like to assure members of the BMA that the Medical Association of South Africa does not require urging or the exertion of pressure to indict unprofessional actions or to protect the ethical integrity of the medical profession.

I would at the same time direct attention to the following facts: (a) that the magistrate who conducted the inquest has referred the records regarding the medical treatment received by Mr Biko to the South African Medical and Dental Council for such action as it may deem fit; (b) that substantial claims for compensation have been preferred by the Biko family against the Minister of Justice, the Minister of Health, and the doctors concerned; and (c) that in the Republic of South Africa, as in Britain, it is a basic tenet of the law that a person is held to be innocent until such time as his guilt has been proved.

In view of the foregoing I submit that it cannot be expected of a responsible body like the MASA to express an opinion regarding the medical treatment received by the late Mr Biko on the basis of newspaper reports—it would, in fact, be highly improper to do so, as the matter is still sub judice.

In conclusion I wish to emphasise that the MASA has the fullest confidence in the South African judiciary and in the SA Medical and Dental Council, who will see to it that justice is done.

C E M VILJOEN

Secretary General,
Medical Association of
South Africa

Pretoria

Wasted women doctors

SIR,—I wish to congratulate Dr Peter Richards (14 January, p 95) on his excellent exposure of current defects in HM69/6 arrangements for part-time training posts—namely, (1) the time taken to set up posts and (2) the frequent lack of available funds. Perhaps he can advise me on how we can convince the Department of Health and Social Security that a lapse of time of between one and two years between application and appointment is inappropriate, as some of the doctors concerned are pregnant and the human gestation period is shorter than this!

Last week I wrote to Sir Henry Yellowlees concerning the draft replacement of HM69/6 which is currently being considered. What follows is the major portion of the text of my letter to him concerning part-time training in hospitals.

"Senior registrar posts. The draft of the successor

to HM69/6 proposes that at senior registrar level the number of part-time posts shall be such that it is neither easier nor more difficult for a candidate to be selected for a part-time post than it is to be selected for a full-time one in their specialty. No one would quarrel with such a provision—least of all the Medical Women's Federation.

"However, the aim of this document will not be carried out unless a new, effective method of funding part-time training posts is instituted. At the moment such posts may have to compete directly for funds with collapsing hospital buildings. Or an employing authority may allocate an arbitrary sum for such posts—and when this has been used all further posts are blocked.

"This contrasts sharply with the position of full-time senior registrar posts. Once these posts are agreed, funding automatically follows. So, if it is really intended that part-time senior registrar posts shall be neither easier nor more difficult to obtain than full-time ones, the present funding mechanism requires drastic revision. The draft document contains no reference to the provision of funds for part-time senior registrar posts.

"The arrangements for allocation of *part-time registrar and SHO posts* are to remain largely unchanged. In their case also no reference is made to funding of posts. The system of allocation of money has been the same for these grades as for part-time senior registrar positions. This means in many cases—no money, so no posts."

In my view no replacement of HM69/6 is worthy of serious consideration unless it contains provision for funding of part-time training posts.

ANNE GRÜNEBERG
Honorary Secretary,
Medical Women's Federation

London WC1

Junior doctors in community medicine

SIR,—Your leading article "Promissory note?" (14 January, p 65) discusses the problem faced by the BMA and the Review Body in obtaining a fair salary for Health Service doctors. May I point out the added difficulties of a numerically small group who are without negotiating strength—the registrars and senior registrars in community medicine?

Community medicine is a new specialty the very survival of which is often questioned. If it is to make a worthwhile contribution to the development of medicine high-calibre doctors must be persuaded to enter the field. The Government has invested large sums in sponsoring and developing training programmes. Unfortunately, it has not invested in trainees. Compared with their clinical colleagues, registrars and senior registrars in community medicine are heavily disadvantaged financially because they are not paid for overtime work. Indeed, those moving from general practice or hospital-based specialties usually take a substantial drop in income. This effectively debars doctors with young families or large mortgages who are dependent on a single salary. Not surprisingly recruitment is poor despite a large number of unfilled consultant posts.

The Expenditure Committee of the House of Commons discussed the problem in their report on preventive medicine¹ and made recommendations. Unfortunately, the Government's reply, *Prevention and Health*,² concentrated on the structure rather than the needs of individuals, apparently contradicting the last Secretary of State's oft-quoted dictum, "People before buildings."

The work of a proper community physician is substantially different from that of a clinician, but the hours and responsibilities

can be as arduous. Nearly four years after NHS reorganisation doctors in the community medicine training grades are still without an agreed form of contract. The Central Committee for Community Medicine set up a 'Trainees' Working Party to resolve the problem. Two important facts have emerged from a survey of trainees. Firstly, 89% prefer a closed contract. Secondly, very few are currently involved in emergency and out-of-hours duties.

Environmental health and infectious disease problems often occur at night and the community physician is responsible for the control of outbreaks. Existing staffing and the need of future specialists to obtain practical experience suggest that registrars and senior registrars should play a part in this work; 96% are prepared to do so if adequately paid. Unfortunately, there is no mechanism by which this can occur. Financial difficulties force many to "moonlight" in order to supplement their basic salaries, and while this may be technically illegal, few are able to give up this source of income to take on unpaid work.

Clearly we have the basis for a productivity agreement under the terms of the current pay code, but to date the DHSS does not appear to have accepted this important principle. We hope that the Review Body will recognise the importance of this matter. Meanwhile, we ask for the support of the medical profession in securing financial parity with other doctors for equivalent effort.

NOEL D L OLSEN
Chairman,
Trainees in Community
Medicine Working Party

London SE11

¹ *Preventive Medicine*. First Report from the Expenditure Committee. London, HMSO, 1977.

² Department of Health and Social Security, Department of Education and Science, Scottish Office, Welsh Office, *Prevention and Health*. London, HMSO, 1977.

Dental anaesthetic fees

SIR,—The fees offered for a dental anaesthetic are indeed derisory. The dentist is expected to present a patient certified fit and properly prepared to receive a general anaesthetic. He must provide a specially set out surgery with trained staff and he is usually too ashamed of the miserly fee to deduct anything from the 40 or 50 pennies that the State offers for the care of a patient's life. Maybe the dentist is expected to subsidise the anaesthetic from the equally miserly fee offered for the extraction.

In my practice I have costed out the exercise. It would pay me to close the surgery and order a taxi at my own expense to take the patient to the nearest hospital or clinic. I do not need to do this because I restrict my National Health practice to patients under 21 years of age. For many years my private patients have subsidised the NHS in this way. But of course the private patient must pay the entire cost of the visit. I hope that doctors who follow the advice given by the BMA (24-31 December, p 1680) will appreciate this.

For years Secretaries of State for Health have followed one another in increasing the tax on dental treatment for the non-priority patient. Now the doctors are joining us; they too cry, "Enough!" And when the present Secretary of State suggests that when we charge a patient a private fee instead of collecting his iniquitous tax we are unethical

it simply shows that, like many of his predecessors, he is a stranger to the meaning of the word.

D N BARBER

Chairman,
East Lancashire and East
Cheshire Branch,
British Dental Association

Manchester

Ban on dental anaesthetics

SIR,—Dr C S Ward (14 January, p 113) refers to the ban on NHS anaesthetics except for cases of hardship in general dental practice which has been recommended by the BMA and supported by the Association of Anaesthetists. He agrees with the proposal that "we encourage the dental practitioners to take on patients only on an independent basis, rather than on the NHS."

Paradoxically, he also apparently believes that NHS practice should continue and that he is supported in this belief since "many (in fact most) anaesthetists doing dental work disagree with this [proposed ban]." The decision of the BMA, however, was supported both by the annual general meeting of the Association of Anaesthetists and a conference representing anaesthetists from every hospital group. If Dr Ward is correct in his view it is surprising that no one else has yet written to tell me so.

MICHAEL ROSEN
Honorary Secretary,
Association of Anaesthetists of
Great Britain and Ireland

London WC1

New consultant contract

SIR,—As one of the majority of part-timers who each week work several sessions in excess of those for which they are paid I do not cease to be amazed at your correspondents with whole-time contracts who, during their uninterrupted weekends, write to you in envious terms of those holding a part-time contract. Perhaps they would like to work the 13 State sessions that I do each week and for this honour surrender £2000 a year from their salary. Surely if a man is worthy of his hire he should be paid accordingly, and if the 10-session contract is reasonably priced, then any criticism of payment for work in excess of this, be it private or NHS, is pure envy and not to be condoned.

Likewise the imposition of financial penalties because private practice is being undertaken in addition to the contracted State sessions is immoral, and it is high time it was tested in court.

JULIAN NEELY

Crawley Down, W Sussex

SIR,—Recently there have appeared letters in the *BMJ* inferring that the proposed new consultant contract will be "unfair" to present whole-time consultants, and that those who wish it should be paid a special commitment allowance for agreeing not to take part in private practice. Speaking philosophically, if one is trying to negotiate a work-sensitive contract there is no place for a payment for *not* doing something. One should concentrate on achieving a proper professional salary for the basic contract with