specialist registration and the EEC. I wish to make it understood that the Overseas Doctors' Association is seeking the right of freedom of movement in the European Economic Community for *all* overseas doctors who are British nationals and fully registered to practise in this country and not specialists only.

S A A GILANI
General Secretary,
Overseas Doctors' Association in the UK
Manchester

Distinction awards

SIR,—Dr C I Haines (18 March, p 721) has missed the point which was made by Drs D B Shaw and G H Hall (4 March, p 582). Some system must exist to ensure that worthwhile extracurricular work is rewarded. Research and development certainly should be, by analogy, if the rewards of private practice attract men of intelligence and energy. It is irrelevant to bring the question of full or part-time commitment into this issue. My colleagues Drs Hall and Shaw are both, incidentally, part-timers.

W B WRIGHT
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Exeter

SIR,—We knew we should risk leg-pulling, but our study of the composition of the advisory committees (18 February, p 456) has provoked letters from two ex-chairmen, Lord Platt (4 March, p 582) and Mr B H Price (11 March, p 652), whose tone (one "standing up to be counted") suggests that we touched a raw nerve. Mr Price and the West Midlands do deserve credit for the local effort he describes to be fair, but we doubt if, even with prior homework, "almost an entire day" is enough to evaluate the order of merit in which to rank several hundred consultants from 20 different specialties, especially when the committees are slanted in their own composition. We have shown that the top seven specialties best at getting awards are, in fact, over-represented on the advisory committees (2879 consultants with 187 seats), three- or fourfold compared with the bottom seven (4544 consultants with 88 seats). It seems that Lord Platt and Mr Price see nothing at all wrong with this ("the most democratic form of award-selection I have ever known"—Mr Price) and, for all we know, they may be right to focus more on our conspicuous personality defects. The impartial reader must decide.

We are glad at Lord Platt's frank admission that secrecy was meant to minimise quarrelling—a good reason but outweighed by far too many others. The ex-chairman's good-humoured digs about underlings and chips and shoulders do nothing to efface our sense of older colleagues who have done precisely what Lord Platt and Mr Price suggest—namely, working out their professional lives, developing their subject with devotion, and attaining considerable reputations here and abroad—yet they approach retirement with nothing.

In pressing his case for the special treatment of those specialties he sincerely admires most Lord Platt asks for butter on both sides of the bread. If intense competition for careers in some fields does produce such an oversupply of distinguished consultants it cannot also

be these same specialties which need the extra cash to keep enough good recruits in this country. It is a shabby argument either way: neither we nor Lord Platt stayed here for the money.

Finally, we were wryly entertained by Lord Platt's suggestion that we take a lead from Cassius ("The fault, dear Brutus, lies not in our stars but in ourselves . . ."), the instigator of a conspiracy to put a knife in a friend's back. The "fault" in Brutus was to have scruples. Et tu, Platt?

S BOURNE
P BRUGGEN

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General practitioners' contract

SIR,—With all the discussion at present going on over a new general practitioners' contract may I please air my own views?

There is nothing whatever wrong with our present contract except that it does not reward us sufficiently for our rapidly increasing work load. The basic idea of a per caput payment is a good one and I personally cannot see anything else being practical or workable considering all the facets of our work. What is needed is a realistic payment for out-of-hours duties, and this must include every weekend from 12 noon on Saturday and must run from 7 pm at night and not 11 pm. This must be a reasonable professional fee for a professional responsibility. Then and only then will the Government, and in turn the patient, realise our worth.

I personally work an eight-hour day from 8.30 am to 6.30 pm. I, of course, have a two-hour lunch break and if I did not I would want to take up alternative employment. What really upsets me is being hauled out of my bed or having to work after my day's work is over for no payment or a payment that is derisory.

Let us opt out of *all* out-of-hours commitment until we are paid what we are worth. The Government can then agree or provide an alternative service—for example, a deputising service. I know that we will all live longer and enjoy our work more.

Let us not "throw the baby out with the bathwater" in our negotiations on a new contract. Let us keep what is a good system and one that has worked for all these years. What we *must* have is a realistic payment for our night and weekend work or, as is our perfect right, opt out of it completely.

D C HOGG
Bristol

"The Way Forward"

SIR,—It is difficult to accept that Mr J A Girling (25 March, p 790) seriously disagrees with DHSS policy regarding allocation of resources.

No one can argue that the pressures arising from continuous increase in population of the elderly loom very large in the problem of achieving a balanced allocation of resources. It is estimated that the number of over-75s, who are the heaviest users of health and personal social services, will rise by half a million over 10 years from 2.3 to 2.8 million. The data quoted by Mr Girling serve to emphasise this point further. It must be

conceded that the policy as outlined in *The Way Forward* has been based on a very careful examination of Health Service requirements, considered as a national strategic problem, and therefore the result of thorough and well-informed deliberations, the emphasis mainly being on increased rationalisation in the use of available resources and more effective use of available staff.¹

It is true that continued development of acute services is essential, but it is not suggested in *The Way Forward* that these services should be drastically cut; the suggestion, rather, is that in view of the growing demand on the available resources for the care of the elderly allocation of resources must inevitably suffer to some extent owing to the need for overall rationalisation because of the financial constraints.

Few areas have enough geriatric beds in general hospitals with immediate access to diagnostic, therapeutic, and rehabilitation facilities; the presence of acute geriatric beds in a general hospital enhances liaison between geriatric medicine and other specialties, which in itself contributes to better use of available resources.² This is likely to achieve improved care of the elderly in general, as very often they have multiple diseases, including possible acute surgical conditions. Improved care of the elderly not only increases turnover, reduces waiting lists, and prevents irreversible deterioration of the patient's condition, but also prevents the blocking of other beds, including acute surgical.

The above measures should not only serve to nullify the effects of any marginal cuts in provisions for acute services as outlined in the DHSS documents but would also benefit the elderly considerably.

N K CHAKRAVORTY

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¹ Department of Health and Social Security, *Priorities in the Health and Social Services: The Way Forward*. London, HMSO, 1977.

² Department of Health and Social Security, *Priorities for Health and Personal Social Services in England*. London, HMSO, 1976.

Wasted women doctors: a fallacy

SIR,—Dr Peter Richards states (14 January, p 95): "To marry the career aspirations of women doctors with their domestic responsibilities has proved both too difficult and too expensive for Britain" (my italics). "Misuse of language pollutes thought," and his statement must be corrected lest it harm not only the future contribution of women in medicine, but, in so doing, the medical profession as a whole.

(1) "Marry," as a metaphor of marriage brokerage between two concepts, is confusing here where the marriage of women to men is obviously relevant. (2) "Career aspirations" are what women who choose to be mothers naturally eschew while remaining dedicated to the practice of medicine. (3) The accepted term is "medical women," as in Medical Women's Federation. (4) "Domestic responsibilities" are borne by both men and women—many a medical man has given up career aspirations, without giving up medical practice, because of his domestic responsibilities. Isn't it the "maternal responsibilities" of some medical women which are irritating our postgraduate sub-dean? His assertion now

reads more clearly as: "To combine medical practice with motherhood has proved both too difficult and too expensive for Britain."

But what is his evidence, what are his criteria? A common fallacy is that women "lose" more professional working years than do men. But statisticians and actuaries tell us that women have four more such years to offer in the first place, which makes them a "better buy" for the £30 000 training cost he quotes (his only figure). Even women who choose motherhood can subtract four whole or eight half-time years and still equal their brothers', though not their sisters', contribution. Not that any medical woman would follow Dr Richards's unworthy "mislead" to suggest that it is medical men who are "too difficult and too expensive for Britain"! We value them as we hope we are valued and can only deplore such mindless discrimination.

Medical women recognise that they are no exception to the common experience that motherhood is a full and long-term commitment which is not compatible with career aspirations but is wholly compatible with medical practice. Choosing to be mothers, we are free to fill posts which meet patients' not "personal career" needs. To demand careers as well, or to allow politicians to demand them for us, is greedy and attracts justifiable hostility from those colleagues who have not this happy commitment and who rightly see us as wanting "all this and heaven too." Only a negligible minority of medical mothers does so demand.

MARGARET AGERHOLM

Leatherhead, Surrey

Occupational health service for the NHS

SIR,—I see that the Occupational Health Committee of the BMA (11 March, p 664) has again been discussing this theme. For those of us who have been running departments of occupational health for some years the lengthy discussions about the status of the consultants needed to organise such a service and to provide training programmes seem to be yet a further delaying tactic towards recognition of the role we fill now.

Neither nursing nor medical staff get recognition as occupational health practitioners in the NHS. On a personal level I, as a part-timer, get remunerated as a clinical assistant and the experienced occupational health nurses as ward sisters (Salmon grade 6). An attempt by the area health authority to allow me to be considered as a hospital practitioner was rejected by the regional board some months ago, as an "occupational health pay structure was expected soon." Having been involved in this field in the NHS for nearly 20 years, and with a full department, responsible for 5000 employees, for five years, I wonder how soon is soon.

Some of the proposals for consultants in occupational health seem to us at present unobtainable although ultimately desirable. Is it too much to suggest that we part-timers could be regarded as industrial medical officers and remunerated accordingly, a suggestion a working group of the Occupational Health Committee recommended in February 1975? Can the "Indians" get consideration now? The "chiefs" can follow.

P K WILSON

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Points from Letters

Drug treatment of chronic stable angina pectoris

Dr K BRUYNEEL (Hoboken, Belgium) writes: In your leading article on this subject (25 February, p 462) . . . in the paragraph dealing with long-acting nitrates a distinction should have been made between pentaerythritol tetranitrate, erythrityl tetranitrate, etc, and isosorbide dinitrate (ISDN). You ignore the different bioavailability and pharmacological characteristics between the different kinds of ISDN available on the market such as sublingual, oral chewable, dual action, and retard forms and the differing strengths and dissolution and absorption rates according to the brand of tablet used. Recent publications have reported excellent results with long-acting nitrates. . . . In addition you present the classic pharmaceutical compounds in angina pectoris separately but do not comment on any combination. The era of monotherapy in ischaemic heart disease is long past. Combination of beta-blockers with ISDN is standard treatment today in many Western countries.¹⁻³

¹ Russek, H I, *et al*, *Circulation*, 1968, **38**, 168.

² Zetterquist, S, *et al*, *Current Therapeutic Research*, 1975, **17**, 139.

³ Baxter, R H, and Lennox, I M, *British Medical Journal*, 1977, **2**, 550.

Medicine and the humanities

Mr P CULLIS (Birmingham) writes: . . . At the University of Birmingham, where I am a medical student, there is but one lecture in the course on medical ethics. At many medical schools there are none. Historically, scientific thought has outpaced the philosophical basis upon which the ideas are founded. Newton, after all, invoked the concept of vanishingly small quantities to create the calculus long before philosophers had given the concept meaning. There are many areas of medicine today without adequate philosophical underpinnings, such as the problem of how to distribute fairly scarce medical resources. As Sir William Osler put it, "By the neglect of the study of the humanities, which has been far too general, the profession loses a very precious quality."

Patient's all-in medical card

Dr H JACOBS (Severalls Hospital, Colchester) writes: . . . Would it not be reasonable and proper for every patient to be issued, probably by his or her general practitioner, with one comprehensive medical record card, which could be quite neat and need not be very large, on which are recorded all the drugs he is having and their doses? He could show this to any doctor, either general practitioner or specialist in hospital. If he gets knocked over and has to have an operation and carries it on him, then the anaesthetist will know what incompatible drugs the patient is on. . . .

Preventing mismatched transfusions

Dr L J DONALDSON (Department of Community Health, University of Leicester) writes: . . . Unless the correct details are recorded at the point of labelling the tube containing a venesection sample it is possible, if there is no prior knowledge of the patient's blood group,

for the wrong sample of blood to be processed without the error being detected by checks later in the system. . . . It is a not uncommon sight to observe a new surgical dresser carrying a receiver containing several samples of blood to the end of the ward before labelling them. Given the high standards already in existence to prevent a mismatched transfusion, might it not be worth while incorporating a further safety device into the system? Perhaps a member of the nursing staff could be required to verify, with the doctor, the patient's details so that they are transferred to the specimen tube by the bedside and both parties sign their initials.

Fetal malformation after Debendox treatment in early pregnancy

Dr C J G MENZIES (Dovercourt, Harwich) writes: Drs Dian Donnai and R Harris (18 March, p 691) reported three cases in which patients took Debendox (dicyclomine hydrochloride 10 mg, doxylamine succinate 10 mg, pyridoxine hydrochloride 10 mg) early in pregnancy and subsequently gave birth to babies with abnormalities including exomphalos. I would like to report a further case. . . . A 23-year-old primigravida who had been taking contraceptive pills for six years . . . had a withdrawal bleed on 9 November 1976, having finished a 21-day course on 5 November. She took no more pills and came to the surgery on 30 December saying that symptoms of pregnancy, including severe nausea and abdominal distension, had started on 23 December. A pelvic examination confirmed early pregnancy. She was given Debendox tablets, two nightly, starting on 30 December and continuing until the 20th week of amenorrhoea. . . . The pregnancy was otherwise uneventful except that the presenting part was not engaged in the pelvis at 36 weeks and . . . elective lower segment caesarean section was performed at term. A male baby weighing 3.98 kg was delivered who was subsequently found to have a patent vitello-intestinal duct, which was resected. . . .

Miss KATHLEEN FRITH (Rush Green Hospital Romford, Essex) writes: . . . I have just terminated a pregnancy of 22 weeks' gestation in a patient who was severely ill with diarrhoea before she conceived. Among other drugs she was given Debendox very early in pregnancy, two at night. The fetus proved to have complete exomphalos, absence of one leg, exocardia, bilateral harelip, and kyphoscoliosis. This is an unusual combination of abnormalities and, I believe, confirms the comments made by Drs Dian Donnai and R Harris (18 March, p 691).

Traumatic tenosynovitis of the wrist

Dr J FINER (Chigwell, Essex) writes: . . . I find that this condition often occurs following unaccustomed exercise, such as a person undertaking a repetitive movement of the wrist in a new job. I usually give an analgesic drug, the nature of which is immaterial, and do not in any way bind up the wrist. I advise the patient to abstain if possible from work for one week and have invariably found that in between two and three weeks at the most the condition has cleared up. It would seem that this is a self-limiting condition and does not require any severe measures to treat it.