disease. The latter disease may be more common than what was conveniently known as Friedländer's pneumonia, due to infection with *K. edwardsii* or *K. atlantae*, and must be considered in all severe cases of pneumonia. For this reason and for the very wide antibacterial spectrum, I would advocate that gentamicin and erythromycin be regarded as the drug combination of choice in the face of fulminating pneumonia, particularly one which is not responding to treatment with a penicillin or tetracycline. The combination of gentamicin and erythromycin not only has the virtue that it will cover almost the whole range of bacterial infections, excluding tuberculosis, but also includes cover for at least some *Bacteroides* species, which, admittedly, are very rare causes of pneumonia, and will be effective against *Mycoplasma pneumoniae* infection, though this is rarely the cause of life-threatening disease.

The recently suggested alternative¹ of tetracycline and rifampicin might not have the same wide spectrum cover against Gram-negative bacteria.

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¹ Meenhorst P L, et al, *Lancet*, 1978, **1**, 711.

The abuse of slides

SIR,—It would be difficult for anyone to dispute the excellent advice given by Miss Mary Evans in her paper "The abuse of slides" (8 April, p 905). It is a pity, therefore, that she does not practise what she preaches. Nelson's famous Trafalgar signal is reputed to have read "England expects that every man will do his duty." Perhaps if Miss Evans had looked up everything she quoted and then, as she advises, checked it, she would have seen that her quotation was incorrect.

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Historical importance of outpatients

SIR,—Dr I S L Loudon (15 April, p 974) has referred very briefly to the benefit that accrued to clinical teaching from the establishment of outpatient departments in voluntary general hospitals.

The admission policy of most of these hospitals before the middle of the 19th century was that no patient should be admitted who was suffering from an incurable disease. Moreover, infants were admitted only infrequently, because of the difficulty of nursing and feeding them unless their mothers were admitted also. The result was that students were deprived of clinical teaching on a wide range of conditions they would encounter later in practice.

It was for this reason that an outpatient department was opened in Belfast General Hospital in 1848. Its first physician was A G Malcolm, who has recorded that he made it a rule to examine a number of patients in the presence of students and sometimes allowed them to make the first examination on their own. He found that before long senior students were able to diagnose with considerable accuracy cases of pleurisy, tuberculosis of the lungs, pneumonia, bronchitis, and diseases of the heart. It is, I believe, a backward

step that outpatient teaching has now ceased to be a part of the curriculum in some British medical schools.

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Aminophylline in respiratory failure

SIR,—In his article on respiratory failure (8 April, p 898) Dr R A L Brewis advocates regimens of administration of intravenous aminophylline, which many would now regard as less than cautious. At various points in his article he advises (a) aminophylline 250 mg over two minutes; (b) aminophylline 500 mg over four hours; and (c) "intermittent intravenous injections of nikethamide and aminophylline . . . can be repeated up to every two hours." Serious toxic side effects (cerebral convulsions and cardiac arrhythmias) are known to accompany high plasma concentrations of the drug, and these concentrations arise following too rapid an injection and too high a maintenance dose of aminophylline. Several reports¹⁻⁵ and a review⁶ have drawn attention to these dangers. To achieve a plasma concentration of theophylline of 10 mg/l (which has been shown to be therapeutic in asthma) an intravenous loading dose of 6 mg/kg aminophylline slowly over 15-30 minutes has been recommended,¹ followed by a maintenance dose not exceeding 0.9 mg/kg/h. The patients with respiratory failure for whom Dr Brewis is advocating aminophylline are likely to be severely hypoxic and with diminished cardiac reserves, and may be especially at risk from toxic blood levels. In the presence of congestive cardiac failure the maintenance infusion rates should be reduced by one-third.¹

While it is appreciated that Dr Brewis was possibly advocating aminophylline as a respiratory stimulant as much as for its bronchodilator effect, safer alternative therapies probably exist for both these desired effects (for example, doxapram and nebulised salbutamol) as outlined in his article; but if aminophylline is used it should be given by slower infusion and in smaller dosages than he recommends.

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¹ Pfafsky, K M, and Ogilvie, R I, *New England Journal of Medicine*, 1975, **292**, 1218.

² Merrill, G A, *Journal of the American Medical Association*, 1943, **123**, 1115.

³ Bresnick, H, Woodward, W K, and Sageman, C B, *Journal of the American Medical Association*, 1948, **136**, 397.

⁴ Camarata, S J, et al, *Circulation*, 1971, **44**, 688.

⁵ Nicholson, D P, and Chick, T W, *American Review of Respiratory Diseases*, 1973, **108**, 241.

⁶ *Lancet*, 1973, **2**, 950.

Male altos and counter-tenors

SIR,—Mr Keith Norcross (25 March, p 779) had made comment in *Materia Non Medica* on counter-tenors and found that "occasionally all the counter-tenors we hear sound a little strained," and also that falsetto singing provides "a considerable strain." There is, perhaps, a slight confusion here when one understands the teachings of Russell Oberlin.

Few singers are true "counter-tenors," and most at this range are male altos. The difference is that male altos are singing in falsetto with a break between the falsetto and the normal singing voice, and true counter-tenors do not

have such a break and are singing in the true compass of their voices (or tessitura) as high tenors. It seems that Alfred Deller and James Bowman are singing as male altos and should not be called "counter-tenors" but "male altos."

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Pensions and the freeze

SIR,—A year or two ago we heard—very justifiably—much of the "freeze" on incomes depriving some consultants of salary increments and immediate payment of distinction awards. These increments and awards would, however, finally be paid: they were, therefore, while unjustifiable and unfair (except to politicians), as well as a breach of contract, a temporary deprivation.

There is, to my mind, an even more serious situation in the pension arrangements, arising from this freezing of higher incomes (apart from the paltry £208 of the current financial year), which is permanent and cumulative. I refer to the pension of a consultant retiring after the last pay award by the Review Body, and would consider the position of a whole-time consultant with my length of service (including my war service) due to retire on 31 May 1978.

Had I retired on 31 May 1976 my pension would have been £4163.95 (£10,689 × 31 60/365 × 1/80). On 1 December 1976, an 8.8% increase brought about by index linking would make this £4530.38, and on 1 December 1977 a similar addition of 17.7% would result in my now having £5332.25. Had I retired on 31 May 1977 my pension would have been £4297.56 (£10,689 × 32 60/365 × 1/80), increasing by 11.4% from 1 December 1977 to £4787.48. Retiring on 31 May 1978 my pension will be £4517.40 (10,097 × 33 60/365 × 1/80). The later retirement takes place after the last pay award and before the next one, the worse off the individual becomes—and each time index linking takes place the greater the disparity: for a given percentage of £5332.25 will be greater than the effect on £4787.48, which will be greater than the increase on £4517.40. This calculation has purposely been made on basic pay and ignoring domiciliary visits and distinction awards—but addition of these only increases the disparity.

It seems to me that longer service means diminished pension in the peculiar world our Socialist masters have forced upon us, and this will be progressive and lifelong. On p 2 of the *Daily Telegraph* of 5 April 1978 it is reported that a Mr Graham Puttergill, chairman of a leading pension agency (Anthony Gills Pension Services) spoke of a government concession designed to prevent people near retirement becoming permanent victims of recent pay restraint—in 1974 the Government ruled that pensions could be based on what salaries would have been but for pay restraint. I believe that the BMA must call urgently for the Review Body to pronounce along these lines, and so rectify this calamitous and unfair situation.

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Medicine and apartheid

SIR,—In reply to the letter "Medicine and apartheid" (4 February, p 306), signed by a group of doctors from London SE5, I would