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Correspondents are urged to write briefly so that readers may be offered as wide a selection of letters as possible. So many are being received that the omission of some is inevitable. Letters must be signed personally by all their authors.

So we'll go no more a-jogging . . .

SIR,—When a thoughtful niece gave me a paperback on jogging I knew my future was being eyed and threatened. Too many relatives find my retirement an irresistible signal for urging me to "give up this" and "take up that"—and perversely getting them the wrong way round. The evidence that jogging does a lot of good seems to me quite underwhelming. Still, I believe part of what I am told—that 20 minutes of jogging would be just a token trot, doing nothing convincing for the health.

So sitting myself down with yet another gift, a pocket calculator, I did some sums. That was a mistake, for the answers were palpably ridiculous. Instead I went back to my old-fashioned arithmetic and worked it out like this. If you jog for two hours a day you are jogging for one-eighth of your working life. If, then, as a result you live to 72 instead of 64, what have you achieved? The privilege of jogging for one-eighth of your one-eighth longer life. Very well, but does it make you happier? There are joggers' vests on which are emblazoned the motto: "I'm a happy hoover." Yet the only happy hoover faces I have seen appear in pictures done for an advertisement or some special occasion and obviously posed and composed (well, not decomposed).

They all say they feel alert and happy, but when I see addicts jogging along the highway they look grim and resigned: as well they might be, for everything seems against them. The 25 million regular joggers in the United States are objects of hatred to motorists, who dispute their rights on the road and hurl at them insults and beer cans. Can the explanation

be that in the non-jogging and therefore overweight motorists the thin man who is always fighting to get out of every fat man (as one theory has it) takes charge and relieves his envy by aggression? It is not hard to understand why joggers look unhappy. They have to give up so much that they could enjoy effortlessly and without undergoing the monotony of a treadmill. And they cannot expect any remission of sentence for good conduct—only an extension. The thought of those eight extra years of miserable existence does not entice everybody.

Why, then, do joggers jog? Are we really expected to believe it is necessary to jog because our forebears in the wild hunted for a living? If they went at that jogging pace they would not have caught much—except such ridiculous animals as were also jogging. So many modern joggers parade the paunchy pear-shape of middle age. Those primitive hunters who, we are led to believe, kept their blood cholesterol down and their coronaries open by exercise were dead long before they could ever reach middle age. I would not affirm that the exercise they had to take actually killed them; but I do wonder if exercise late in adult life has the same supposedly good effects on metabolism as before the endocrine orchestra changes from the spring song to the slow march.

Joggers differ from walkers because both feet are off the ground at the same time and from runners because they can keep up a conversation with a companion jogger. But what would they be conversing about? Their

athlete's feet, perhaps?—or their jogger's kidney, which it seems some diagnose as pseudonephritis by examining their urine when they get home after a jog. Bra-less lady joggers bouncing along the road could discuss what I am told they refer to as "jogger's breasts"; and men, who may suffer from "jogger's nipples," can debate whether to pad them or rub in Vaseline. How unattractive it all seems!

My position, then, is that even though jogging is claimed to be an aerobic exercise and non-competitive I refuse to keep what is grandly called a "motivational diary" or to follow the advice to "jog tall." Balletomane Arnold Haskell once wrote: "We must remember that the dancer is both the instrument and the instrumentalist." Jogging may be self-expressive, but never will I concede that it is elegant, aesthetic, or an art form; and to those who might still seek to persuade I shall quote from a Dadaist manifesto: "Any work of art which can be understood is the product of a journalist."

Every few years I tune up my synapses by going in for some quite novel activity. Among the more recent are clarinetting, charity collecting, and conservation. I shall tell my thoughtful niece that blowing, rattling, and preserving keep me fit and amused without any need to jog—except, alas, for my memory.

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Cefamandole and beta-lactamases

SIR,—Standardised data sheets on new drugs are a relatively recent and very valuable service to the medical profession. We must necessarily assume that these sheets incorporate the latest and most reliable published evidence relating

to the drug. However, today I received in the post a new data sheet on cefamandole nafate (Kefadol)—the most recent addition to the ever-growing ranks of cephalosporins—and was disturbed to find that it contained a fundamentally important statement that is contradicted by reports available seven months ago. The antibiotic is described in the data sheet as being "resistant to degradation by penicillinases from *Staphylococcus aureus* and by β -lactamases from certain members of the enterobacteriaceae"; moreover, the promotional letter which accompanied the sheet states unequivocally that "cefamandole has greater resistance than earlier cephalosporins to β -lactamases."

In reality my colleagues and I have shown that cefamandole is highly susceptible to β -lactamases from both Gram-positive and Gram-negative bacteria with the exception of the relatively unimportant type Ia enzyme of *Enterobacter cloacae*, to which the antibiotic possesses a modest degree of resistance.¹ In contrast, greater stability to most enzymes is a feature of some of the well-established cephalosporins, notably cephadrine and to a lesser extent cephalixin. The findings in relation to the enzymes from Gram-negative bacteria have been corroborated by Vuye and Pijck,² who concluded that "cefamandole nafate displayed the highest vulnerability among the cephalosporins tested against the broad-spectrum enzyme" (IIIa or TEM-type). The ability to produce this clinically most important enzyme has evidently been transmitted by plasmids from *Escherichia coli* to the gonococcus and *Haemophilus influenzae* in recent years.³ This alarming trend is likely to negate the one undoubted advantage that cefamandole possesses over other cephalosporins—its enhanced activity against fully sensitive strains of *H. influenzae*.

Unfortunately the manufacturers of this antibiotic are not the only authoritative source of potentially misleading information; in a very recent general review on antibiotics we read that cefamandole is "extremely stable to β -lactamases, especially those produced by Gram-negative organisms."⁴ The general confusion surrounding the cephalosporins has been greatly heightened by the fact that the company in question now markets four of these antibiotics simultaneously in Britain and at least six throughout the world (and yet another new one, cefuroxime, was introduced by a different company last month). A rational choice in this group depends largely on antibiotic stability to β -lactamases.⁵ Cefamandole fails on this score, but several other essential considerations also apply.⁶ In particular, pharmacokinetic features are very important. However, again the picture presented by cefamandole is not very promising since it is relatively highly protein-bound and has a short half life in the body and a relatively low volume of distribution.⁷ This particular "second-generation" cephalosporin seems, alas, ill-qualified to replace the more sprightly of its older relatives.

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¹ Geddes, A, *Medicine* (3rd series), 1978, No 3, p 155.
² Williams, J D, *Journal of Antimicrobial Chemotherapy*, 1978, 4, 109.
³ Selwyn, S, *Lancet*, 1976, 2, 616.
⁴ Gower, P E, and Dash, C H, *European Journal of Clinical Pharmacology*, 1977, 12, 221.

* * * We sent a copy of this letter to the medical adviser to the manufacturers of cefamandole, whose reply is printed below.—Ed, *BMJ*.

SIR,—As Dr Selwyn himself points out, not everyone agrees with his assessment of the stability of cefamandole to β -lactamases,¹ but the more important question is the extent to which such properties are relevant outside the laboratory. For example, later in Vuye and Pijck's paper is the statement that "cefamandole was shown to be by far the most active compound, a property that may probably compensate for the vulnerability of this compound to other resistance mechanisms." Also, in the article by Professor J D Williams is an admission that, unlike penicillins, a clear association of β -lactamase with resistance to cephalosporins is often not obvious even in vitro and that correlations between in-vitro tests and in-vivo results have yet to be established. Specifically in relation to *Haemophilus influenzae* there is, fortunately, clear evidence that strains which produce TEM-type enzyme do not show any increased resistance to cefamandole,² which must cast doubts on the relevance of tests showing cefamandole to be inactivated by that enzyme.

A recent editorial in the *Lancet*³ explained that there are at least three factors to be considered: (1) stability to β -lactamase, (2) penetration through the cell wall and periplasmic space, and (3) inherent antibacterial activity. It is a combination of these factors, not any one of them alone, which determines the effectiveness of cephalosporins; and there is ample evidence, which we would be happy to supply on request, that cefamandole is very well qualified to be considered for use in patients with appropriate infections and as a possible replacement for earlier cephalosporins.

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¹ Farrar, W E, et al, *Journal of Infectious Diseases*, 1976, 133, 691.

² Kattan, S, et al, *Journal of Antimicrobial Chemotherapy*, 1975, 1, 79.
³ *Lancet*, 1978, 1, 863.

The MRCP (UK) examination in Commonwealth countries

SIR,—Since taking up the post of professor of medicine in this university four months ago I have become acutely aware of the problems faced by my junior medical staff when they decide to sit the MRCP (UK) examination. This diploma is highly regarded in Malaysia and Singapore and, now that the Australasian college has changed its regulations, is the only internationally recognised higher qualification in medicine available to postgraduates in South-east Asia.

When I came to Kuala Lumpur I was under the impression that there was no barrier to trainee specialists sitting the part I examination locally, thus sparing them the enormous expense of a journey to the United Kingdom, which could then be deferred until they were ready to sit the part II examination and would allow them to undertake a period of

postgraduate training at the same time. I have since discovered, however, that the part I examination is held only once a year in Kuala Lumpur (Singapore candidates have also to come here for the examination). Thus in the event of failure (and this fate can befall even a very well-prepared candidate) he or she cannot sit the examination again locally for a period of 12 months. This, as can be imagined, places an immense strain on candidates and interferes seriously with their hospital training programme. All that is bad enough, but it has now come to my notice that the number of candidates admitted to the part I MRCP (UK) examination in Kuala Lumpur is restricted to 150 and that because of the demand for places the list is closed almost as soon as it is opened. Consequently many excellent candidates (and the standard of medicine in Malaysia and Singapore is not far behind that of the United Kingdom) are, through no fault of their own, being denied the opportunity of even sitting the part I examination.

I took up this matter with the president of the Royal College of Physicians of Edinburgh, who made the rather lame comment that because of administrative difficulties the number being allowed to sit the part I examination overseas is severely restricted. While I can appreciate that it might be difficult (although not impossible) to increase the number of part I examinations per year in countries like Malaysia, it would surely not be beyond the capability of the royal colleges to relax the restrictions imposed on the number of candidates. It cannot be much more difficult to collect and correct (by computer) 200 instead of 150 multiple-choice question papers.

In these days of declining British commercial influence it is very encouraging that British medicine and British medical qualifications should enjoy such a high reputation in this part of the world, and I feel sad that the royal colleges are apparently not prepared to make a positive effort to help young Commonwealth medical graduates and the medical schools which are training them by easing the present restrictions on the part I MRCP (UK) examination. This would, I suspect, be of much more practical value than "goodwill" visits by presidents to countries where these restrictions exist.

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The Rothschild principle

SIR,—In reviewing the results of applying the Rothschild recommendations to medical research (6 May, p 1167), you not only ignore what was just and sensible in Rothschild's criticism of the previous system but fail to make any constructive suggestions about how they might be met.

We are particularly concerned by at least one aspect of the manner in which the Medical Research Council categorises and organises its coverage of medical research and, as representatives of the British Paediatric Association, have expressed this long ago to the council. Although such important clinical areas as obstetrics and embryological and fetal growth are concealed by the incomprehensible title of the responsible "cell biology and disorders" board, these subjects do appear to be

¹ Imambaccus, Y, et al, in *Current Chemotherapy*, ed W Siegenthaler and R Lüthy, vol 1, p 495. Washington, D C, American Society for Microbiology, 1978.

² Vuye, A, and Pijck, in *Current Chemotherapy*, ed W Siegenthaler and R Lüthy, vol 1, p 492. Washington, DC, American Society for Microbiology, 1978.

³ *British Medical Journal*, 1977, 1, 1618.