clinical situations. The possibility of an interaction occurring could be further reduced if the antacid preparations are given, as is usually recommended, between meals and the digoxin as a single daily dose before or with food.

J COOKE

Department of Pharmacy,
St James's University Hospital,
Leeds

J A SMITH

Department of Pharmacy,
University of Bradford

¹ Khalil, S A H, *Journal of Pharmacy and Pharmacology*, 1974, **26**, 961.

² Brown, D D, and John, R P, *New England Journal of Medicine*, 1976, **295**, 1034.

Management of dermatomyositis

SIR,—The management of dermatomyositis in patients over the age of 40 (Any Questions? 30 September, p 938) should include a search for occult carcinoma. Dermatomyositis in this age group is frequently associated with anti-tumour antibodies either cross-reacting with striated muscle and skin elements¹ or reacting at these sites with tumour antigen released into the circulation.² Removal of the tumour (oesophageal carcinoma may be preceded by a long history of chronic inflammation) often results in remission of dermatomyositis.

J R JASS

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London SW1

¹ Alexander, S, and Forman, L, *British Journal of Dermatology*, 1968, **80**, 86.

² Turk, J L, *Immunology in Clinical Medicine*. London, Heinemann, 1972.

*Our expert writes: "The association of neoplasms with dermatomyositis is well known. Described 25 years ago,¹ it is featured in standard textbooks.² Thus the comment in the question that the man was in excellent health was taken to imply that an associated neoplasm was unlikely. It is, however, of course correct to consider this possibility both at the onset of dermatomyositis and at follow-up visits."—Ed, *BMJ*.

¹ Curtis, A C, Blaylock, H C, and Herrell, E R, *Journal of the American Medical Association*, 1952, **150**, 844.

² Hart, F D, in *Textbook of the Rheumatic Diseases*, ed W S C Copeman, 4th edn. Edinburgh, Livingstone, 1970.

Pricing the consultants' contract

SIR,—At the meeting of the Central Committee for Hospital Medical Services on 21 September (30 September, p 974) it was made clear that the new consultant contract was in the doldrums owing to the refusal of the Review Body to price it except as part of an April 1979 review. (The refusal to produce an interim report indicates that it has not been swayed from its expressed intention¹ to regard the pricing of the new contract as a mere redistribution exercise and not as a genuine attempt to place a fair value on its various elements.)

Worse, it was stated that the employing authorities anticipated that a minimum of six months would be required for implementation from the time of acceptance of the priced contract. Why it should take so long was not explained; but in an attempt to expedite

implementation it was suggested that the employing authorities should be empowered to approach consultants about their intentions with regard to the new contract and for an estimate of the number of notional half-days (NHDs) they would require. The previous review of consultants' hours of work² was dismissed as inaccurate and likely to lead the Review Body to undervalue the NHD—but how the new survey would be made more accurate and how it would avoid the latter pitfall was unclear. Indeed, it seems dubious that the proposed information could expedite implementation. Fortunately the CCHMS rejected the idea, but a compromise was reached leaving the executive free to explore the possibility of conducting its own inquiry.

The executive should abandon any notion of so doing and concentrate on the main problem of the contract: to have it adequately priced as soon as possible. It must keep in mind that the pricing will be unacceptable unless the salary scales for the existing whole-time contract relate only to the 10 NHDs of the basic new contract. As there is no hope that the Review Body will do this (it may botch together some complicated deal which will still be unacceptable—for example, pricing the contract as above by using the cash promised for 1979 and 1980 to finance it, those salary rises then being forgone), the sooner that it is flushed out into the open the better. The profession will then be left with the choice of abandoning either the new contract or the Review Body. The latter will be the sensible move and one which the juniors have had forced on them by the Review Body's inability to cope with their new contract.

TOM MCFARLANE

Manchester

¹ Review Body on Doctors' and Dentists' Remuneration, *Eighth Report*, 1978, p 18. London, HMSO, 1978.

² Review Body on Doctors' and Dentists' Remuneration, *Eighth Report*, 1978, appendix D. London, HMSO, 1978.

Use and abuse of medical women

SIR,—Scrutator (7 October, p 1031) has reported our recent meeting in Birmingham on "the use and abuse of medical women." This meeting was originally planned by Birmingham and District Medical Women's Association to bring to the notice of our colleagues, male and female, the continuing need for the existence of the Medical Women's Federation. The lively debate following the talks by Dr Anne Gruneberg and Dame Josephine Barnes certainly underlined the problems still faced by medical women in 1978.

I hope that Dr Mary White will not be upset if I include her, with myself, as an older medical woman. There are several differences in circumstances nowadays from when her children and mine were small. The difficulty in getting domestic help and its cost compared with our salaries has increased many fold. Postgraduate training is now necessary (if not yet mandatory) in all branches of medicine. Three main conclusions must be drawn: (1) Medical women will suffer financially if there are not some changes—for example, cost of domestic help given income tax relief. (2) Women medical graduates must realise what is ahead of them and plan accordingly—for example, possibly complete their training before starting a family. (3) Medical colleagues who consider and give advice on postgraduate

training and availability of part-time jobs should bear in mind the problems of medical women. One of our members has commented to me, "It is surely desirable that all intelligent women should have the same right to procreate as other women and that their children should also have the same right to parental care as other children."

We recognise the possibility of future over-manning (or should I say over-personing?) in the medical profession. The profession must stand together on this problem of medical manpower to prevent a situation arising in which there will be unemployment; in these circumstances women would be likely to be the first to be affected.

PATRICIA E PRICE
President,
Birmingham and District
Medical Women's Association

Birmingham

Payment of ancillary staff

SIR,—I note the considerable discussion now prevalent regarding payment to general practitioners' ancillary staff. What I have not seen mentioned, and is of the greatest importance, is the situation caused by "natural wastage."

Like many practices, ours has been trapped in the successive pay restrictions so that we have only been able to raise salaries on the annual percentage basis. In our opinion our staff were originally remunerated adequately on the then existing market rates. But of course the private sector has been quietly uprating secretarial salaries far beyond Government guidelines, either quite openly or masked under various "deals."

We are now faced with two unpalatable facts. Existing staff who have been with us for years and are worth their weight in gold are being paid way above salaries that the family practitioner committee will reimburse. Secondly, and much worse, new staff must be paid at the same *old* rates as the original staff. We are now paying our secretaries and receptionists over £1000 per annum above original rates which are not reimbursable. Thus we are losing more than £700 per annum from legitimate income. We even tried to turn our senior secretary into a practice manager, but that approach got a very dusty answer. So a good part of our "rise" is going straight out to staff and other practice expenses, resulting in a financial standstill for the doctors.

Finally, we note that many applicants for secretarial posts at £1.50 to £2 per hour are utterly incompetent. Their grammar is appalling, they can't spell, and half seem to suffer from dyslexia. Perhaps the Government does know best even if its interpretation of reimbursable salaries for ancillary staff is outrageously immoral.

H P WATSON

Mitcham, Surrey

Prescribing and family planning

SIR,—Prescribing is an integral part of medical practice and only a doctor may prescribe. Prescribing can never be delegated to anyone, even another doctor, for each doctor must be responsible for his own. No nurse does, can, or ever shall prescribe. This last because no defence society will ever indemnify any doctor against deliberately covering a person unqualified in this respect, such as a nurse.

What the family planning nurse has been doing is what the delegating doctor has asked her to do having regard to her competence—write up the patient's requirements. This is *not* a prescription. To say it is at best a misunderstanding, at worst a downright lie. The actual prescription resides in the doctor's scrutiny, agreement, and signature. If it is claimed that in family planning clinics, as is the case, patients leave with supplies before the doctor has actually signed this is merely a convenience with very, very little risk attached for anyone relying upon good faith and the high standard of nursing care, for if the doctor disagrees he will not sign and will immediately seek recovery of the supplies, as he would if an error had occurred. The nurse is protected because in delegation she is acting on the doctor's instructions (though she is, of course, required to act at all times responsibly and competently as a qualified nurse). The risk in this practice must be much less than that of a chemist's counterhand delivering the wrong package. By the way, does anyone regard such a person to be "prescribing"?

The other piece of humbug being circulated in the press is that the family planning services will collapse unless nurses are allowed to prescribe. Rubbish. If the delegating doctor writes up and signs every patient's oral contraceptive requirements, the work of a moment, before the patient collects supplies the clinics may proceed completely as normal.

The present "brouhaha" about nurses' liability for "prescribing" seems to have originated from an interpretation of part of the Medicines Act by the Royal College of Nursing which, as may be seen from the above, is misconceived.

N CHISHOLM

London NW3

Facilities for private practice in NHS hospitals

SIR,—It has been your recent practice to publish each set of consultative proposals put out by the Health Services Board for the withdrawal of facilities for private practice from NHS hospitals. This form of publicity has been very helpful to the profession and the board, but special problems arise in connection with the most recent proposals (21 October, p 1103) and I would be grateful for the opportunity to comment on them.

On this occasion the board is writing individually to each hospital or group of hospitals affected, the texts varying in detail, so that it is more difficult for you to publicise the matter. The board is, in addition, sending sufficient copies of its letter to each health authority to allow circulation to every consultant engaged in private practice, so that the fullest publicity is being obtained for its proposals in another way. However, the important change in the board's procedure on this occasion is that it is concentrating upon places where alternative facilities outside the NHS are available but, in the board's view, under-used and proposing reductions in NHS authorisations calculated to raise the occupation of the local nursing home to near 75%.

The board is fully aware that the existence of vacant beds in a nursing home does not necessarily imply that they would be suitable for private patients presently being treated in

NHS hospitals, because the supporting facilities in the nursing home may not meet the requirements of many of the patients concerned. However, it has placed the onus for demonstrating this upon the profession, who are, indeed, the only people with a full knowledge of the facts. As it may not be immediately obvious to all consultants how best to prepare and present evidence to the board to challenge their present proposals where they are invalid, a letter has been prepared suggesting how the task can be tackled and it is being sent to the chairmen of the medical executive committees of all hospitals affected by the latest exercise.

It cannot be too strongly emphasised that every consultant affected must involve himself in the preparation of an adequate response from his hospital or group. It is impossible to act from the centre in this matter because only the local people have the necessary information and can exercise a judgment regarding the suitability of the local nursing home for the treatment of the kinds of cases which they undertake. Failure to respond may lead to the unnecessary loss of essential authorisations, with serious damage to private practice, in the affected localities. If any consultant concerned needs additional copies of our letter of guidance, or has specific questions to ask, communications to Mr R Woods, Secretary of the CCHMS, at BMA House will ensure any help that we can give. The final date for responding to the board's proposals is 8 January 1979, but the time to start preparing your reply is now. It is vital that this matter is dealt with fully and effectively by every consultant whose NHS beds are under threat.

D E BOLT

Chairman,
CCHMS/JCC Joint Subcommittee on
Independent Medical Practice

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Points

Taking medical histories through interpreters

Dr H H W BENNETT (Trowbridge, Wilts) writes: The article by Dr John Launer (30 September, p 934) interested me very much, having had to cope with this problem in four very different languages during my early years as a missionary doctor. Dr Launer gives some very useful advice, but I should like to add one very important suggestion, and that is that the doctor should listen carefully to what both the interpreter and the patient are saying instead of merely waiting for the answer. Many sentences and phrases will be frequently repeated in the many histories and in a surprisingly short time the doctor will find that he or she is understanding much of what is said; and a little later (in weeks rather than months) can begin to take an active part in the conversation. . . .

Use of orthotolidine

Mr A R Lyne (Ministry of Agriculture, Fisheries and Food, Bristol) writes: I was very surprised to see reference to the use of orthotolidine for testing for free chlorine in water (30 September, p 935). Orthotolidine has been

recognised as a carcinogen and its use in the UK is controlled by the Carcinogenic Substances Regulations 1967.¹ The most convenient alternative to orthotolidine is the DPD reagent (*N,N*-diethyl-*p*-phenylene diamine sulphate), first described by Palin,² which is now universally accepted. The reagent is commercially available in tablet form.

¹ Muir, G D, *Hazards in the Chemical Laboratory*. London, Chemical Society, 1977.

² Palin, A T, *Proceedings of the Society of Water Treatment and Examination*, 1957, 6, 133.

Pain after hip replacement

Mr B M WROBLEWSKI (Centre for Hip Surgery, Wrightington Hospital, Wigan, Lancs) writes: The very interesting article by Dr I W McDowell and others on "A method for self-assessment of disability before and after hip replacement operations (23 September, p 857) wrongly assumes that pain the patient is complaining of must necessarily come from the hip.

Pulmonary oedema associated with suppression of premature labour

Dr M J A MARESH (Queen Charlotte's Maternity Hospital, London W6) writes: The idea put forward by Mr H R Elliott and his colleagues (16 September, p 799) that women should be screened for cardiac lesions before administration of glucocorticoids plus sympathomimetic drugs in premature labour is impracticable. Cardiovascular examination should have been performed at booking and any suspected abnormality referred for a specialist opinion. The time to diagnose abnormality is not when a woman is admitted in premature labour, since cardiovascular auscultation may be confused by her anxiety-induced tachycardia, and the time involved in obtaining cardiovascular investigations and consultant opinion may well allow premature delivery to proceed.

Polio immunisation of parents

Dr J W MCCRONE (Neston, Wirral, Cheshire) writes: I am unable to agree with the suggestion in a recent Department of Health and Social Security circular (CMO(78)15, CNO(78)12) that the unimmunised parents of children receiving oral polio vaccine should also be offered immunisation in order to protect them from the very small risk of contact vaccine-associated poliomyelitis. In a leading article (23 September, p 845) you state that this risk is only 0.1 to 0.6 per million doses and that "these are maximal estimates of risk, based on circumstantial evidence." Most children are brought to the surgery by one parent only and so I do not think it is feasible or justified to follow the Department's recommendation.

Correction

Cervical presentation of rectal carcinoma

We regret that the above title, which was given to the letter from Mr T I S Brown and Dr G L Ritchie (16 September, p 832), is incorrect. It should read "Massive metastatic disease of the foot from primary cervical tumour."