lymphocyte PHA responsiveness¹ this might prevent sensitisation occurring.

Our first patient had had a skin eruption for 25 years which was diagnosed as mycosis fungoides in 1974. She was started on PUVA therapy in 1976, since treatment with electron beam, cyclophosphamide, ICRF 159, and localised irradiation had failed. This was highly successful until this year, when relapse occurred—including the development of tumorous lesions between the fingers, in the natal cleft, under the axillae and breasts, and in the groin (that is, areas shielded from the UVA, a not-uncommon observation with photochemotherapy). There was no lymphadenopathy, but her skin lesions and diminished lymphocyte responses to PHA suggested that she had incipient stage III disease at this time. It was decided to start her on daily topical nitrogen mustard therapy (200 mg/l) and continue her thrice weekly PUVA. The disease was completely cleared after four weeks' treatment, but at five weeks she developed a severe contact dermatitis. She has had a total PUVA dose of 333 J cm².

The Scandinavian findings are important, but we question whether they could be due to the development of anergy due to disease progression,² since retesting to mustine was carried out many months or years after the original contact sensitivity occurred.

ANTHONY DU VIVIER

Dermatology Department,
King's College Hospital,
London SE5

DOROTHY VOLLUM

Skin Unit,
Lewisham Hospital,
London SE13

¹ Kruger, J P, Christophers, E, and Schlaak, M, *British Journal of Dermatology*, 1978, **98**, 141.

² du Vivier, A, et al, *Cancer*, 1978, **42**, 209.

Persistent excretion of salmonellas

SIR,—Your note on "Persistent excretion of salmonellas" (12 August, p 509) was very instructive, but we would like to give some additional information.

In the case you described the presence of salmonellas was only determined qualitatively and the method was not indicated. We have carried out an investigation on the quantitative aspects of salmonella excretion in both infants and adults (the data will be published shortly). Typical excretion patterns are presented in the graphs. In general, infants may excrete high numbers of salmonellas for a much longer period of time than adults, but high numbers

(10^3 – 10^7 per g) of salmonellas may also be found in the faeces of adults for several weeks after clinical salmonellosis. From laboratory quality assurance programmes carried out by the regional public health laboratories we know that with the direct plating procedures salmonellas will be detected only when their number exceeds more than 10^3 bacteria per gram. With our method, using pre-enrichment prior to selective enrichment and plating, less than one salmonella per gram can be detected (when more than 1 g of faeces is examined). Especially during the last period of excretion, when the numbers are frequently 1 – 10^3 , the method of examination becomes of utmost importance with regard to the "free from salmonellas" declaration and the consequent procedure.

M VAN SCHOTHORST
H J BECKERS

Laboratory for Zoonoses and
Food Microbiology,
National Institute of Public Health,
Bilthoven, Netherlands

Grommets and swimming

SIR,—I feel I must also take issue with your expert's advice (5 August, p 420) that children with grommets in their ears "should not be allowed to swim because of the danger of water-borne bacterial otitis media." The hole in the grommet is too small for water to pass through it unless there is a marked pressure difference between the middle ear and meatus, a condition the grommet prevents. I have attended hundreds of children with grommets in their ears to swim and have not had a case in which I have found it responsible for otitis media. In fact, I believe that it is safer for children with a tendency to otitis media to swim with a grommet than without one, as the middle ear infection in these cases is usually initiated by irritation of the nasal and postnasal mucous membrane by the chlorine of the swimming pool water, leading to swelling of the eustachian tube lining, eustachian obstruction, and subsequent middle ear infection. A functioning grommet prevents the damaging effect of eustachian obstruction on the middle ear and thus makes it safer for these children to swim in chlorinated pools. Swimming is a healthy and often favourite exercise in the age group in which glue ears are common, and in the interest of these children it is high time that the commonly held belief that they should not swim with a grommet was debunked.

P E ROLAND

Rugby

Royal College of Surgeons of Edinburgh: reform of fellowship examinations

SIR,—At the annual meeting of the Fellows of the Royal College of Surgeons of Edinburgh on 18 October it was resolved by a large majority of those fellows present and voting that "the Council be hereby empowered (1) to introduce a new examination in the surgical specialties to be taken after the Part II fellowship and leading to the award of an additional diploma distinguished by the name of the specialty; (2) to decide on an appropriate title for the new diploma." There has been so much misunderstanding about the proposals which Council made last year for the reform of the fellowship examinations that I shall be grateful if you will allow the space to

explain what were the proposals that we made last year.

The new Part I examination was to comprise the applied basic sciences and the principles of surgery in general, and was to be taken when the basic training in surgery had been completed about three years after registration. The new Part II examination was to be taken in one of the recognised specialties, and the suggestion was that the candidates should have completed a minimum of three years' training in their chosen specialty in posts approved for this purpose by the college.

Last year the fellows asked Council to consult widely with the other colleges, the Association of Professors of Surgery, and the specialist associations. We have done this, but we have not been able to persuade the other colleges and some of the specialist associations to accept our original proposals for the revision of both parts of the examination. We realised that, if we introduced this revision without the co-operation of the other colleges, we would be isolated and the reciprocity which at present exists between the British colleges would be lost. This reciprocity is a very important aspect of the relationships between the colleges.

The training programmes administered by the Joint Committee on Higher Surgical Training have had a remarkably beneficial effect on the development of the surgical specialties and on British postgraduate surgical training. The Council feels very strongly that the fellowship examinations in their present state do not bear a proper relationship to British surgical postgraduate training and to the requirements for specialist recognition. We very much regret that the proposals which we put to our fellows last year for the reform of the fellowship examinations have had to be shelved. We therefore tried to find an alternative which would improve the present situation while not disturbing the present arrangements for the examinations. Although the present form of the fellowship examination is constantly under review the basic structure has not been changed during the last 15 or 20 years, during a period when there has been a rapid increase in the sophistication and complexity of every field of surgery. Therefore some formal assessment of the standard achieved by those in training ought now to become the proper responsibility of the colleges. The proposals which we have now been empowered to implement are the first step in what we firmly believe will be a gradual movement towards the achievement of the proposals which we made last year. There can be no doubt that this must not only be a gradual movement but that it is also one which is long overdue—we must make this change and make it now.

These proposals mean, firstly, that the present Parts I and II of the fellowship examination should continue undisturbed and that they will be taken at the same stages in training as at present. Secondly, in addition there will be an examination in the chosen specialty to be taken during specialist training. This will consist of an oral examination in the applied basic science of the chosen specialty, a clinical examination, and a systematic oral in the surgical aspects of the specialty. The advantages of this proposal are, firstly, that they do not disturb the present arrangements for the diploma of fellowship or the reciprocity with the other British colleges, and, secondly, that the specialist diploma will open the way to securing reciprocity with the

Typical salmonella excretion patterns in infants and adults.

specialist bodies throughout the world including the EEC and North America. This additional specialist examination will be an optional one.

ANDREW WILKINSON

Royal College of Surgeons,
Edinburgh

Dental anaesthetic fees: all is now clear

SIR,—After legalistic rereading of the eighth report of the Review Body on Doctors' and Dentists' Remuneration (1978) it is now clear to me that the scale of fees at present payable under the general dental services statement of fees and allowances for the anaesthetic is intended to apply only to general dental practitioners working with their partners in the same practice, because no provision is made for the cost of mileage or the provision of equipment.

It will be recalled that the scale of dental anaesthetic fees is as follows: for 1-3 teeth extracted—£2.00; for 4-11—£2.60; for 12-19—£3.50; for 20 or more—£4.60; for any anaesthetic given by a dentist operator—£0.60.

These fees are clearly too low to remunerate the general medical practitioner called in to give an anaesthetic, for whom the Review Body scales are increased as follows: administration of nitrous oxide or ethyl chloride—from £4.60 to £5.75; administration of any other general anaesthetic—from £7.65 to £9.55. (Presumably general dental practitioners called in from outside to anaesthetise should be paid on a similar basis.)

Still less does the present scale meet the case of the consultant (anaesthetic or dental) called to give a dental anaesthetic—in this instance a domiciliary scale fee is clearly earned, because the skill, work, and responsibility involved are higher than those in other instances of domiciliary consultation. Again, it will be recalled that a consultant can be called in for a domiciliary visit whenever the general practitioner considers the need is justified; the scale of fees advised by the Review Body is to be increased from £10.90 to £12.30 a visit. Additional fees are payable for mileage and for the use of equipment.

When will the Secretary of State see fit to honour their obligations in the interest of the public seeking dental treatment?

CYRIL SCURR

Magill Department of Anaesthetics,
Westminster Hospital,
London SW1

Use and abuse of medical women

SIR,—Scrutator reported my views (7 October, p 1031) as expressed at the recent meeting in Birmingham with accuracy. Dr Patricia Price, in her letter (21 October, p 1167), obviously disagrees with some of those views (as she is entitled to do), but since she has expressed herself at some length I must reply to her letter, as the initial report was naturally brief.

While there remain shortages, women doctors have indulged in certain demands. I stated that when we eventually get to a stage of overmanning women would have to maintain a realistic approach. This in no way denies part-time work, or children; but having made a decision to offer full-time or part-time work they must see that they fulfil that particular

commitment. This has nothing to do with not seeking proper tax reliefs, but male and female colleagues will expect them to arrange their personal lives so that they offer a proper commitment at whatever level they have sought. They must therefore be good organisers and be willing, out of the joint incomes, to contribute financially to give adequate domestic support. The women must not expect her income to be as profitable as if she were without husband or children. Patricia Price is also wrong in her comparison of former costs of domestic help relative to salary. It is a question of attitudes. Women doctors will get just as much equality as they are willing to compete for, even allowing for special arrangements.

I stated that I have considered crèches were not really as helpful to doctors as they have been to nurses. The latter more often work as part of a team; a doctor is more likely to work on her own—and what happens when her child has measles and cannot go to the crèche, and she is committed to an operating list or an outpatient session? It also needs to be stated that during school age there are long school holidays which must be catered for, and that young teenagers may be, in different ways, as demanding as very young children. However, the trend of society towards a more sharing parental role should be noted.

In the early years women in medicine looked for opportunities to train and opportunities to work. My main theme is that because of a period of shortages, when it has been easier for women to work, let us by all means look for satisfactory arrangements for training and for work and tax reliefs; but let us not make unrealistic demands and complaints so that medical women of the future are denied a right to work—on equal terms if they wish. When there is overmanning, they will have to pay particular attention to making satisfactory back-up arrangements for whatever level of commitment is offered, as I would hope women do at present.

MARY WHITE

Bromsgrove, Worcs

The Glanvill case

SIR,—“Scrutator” (30 September, p 969) quotes remarks I made to the General Medical Services Committee about the Glanvill case (in which Dr Glanvill successfully challenged the exclusion of his wife from the ancillary staff payments scheme for general practitioners). I wish to clarify certain matters. I referred to the introduction at a late hour of a new claim which challenged the integrity of the Secretary of State. The Secretary of State's power to exclude wives had been challenged from the start of the action in 1976. During the trial Dr Glanvill's counsel submitted that from the original statement of claim it was open to him to argue that the Secretary of State had not only exceeded his powers but also acted unreasonably. DHSS counsel considered that the argument about what was reasonable should be specifically pleaded and so the statement of claim was amended during the course of the trial. I have been informed that it was not part of the Glanvill's case to challenge the Secretary of State's personal integrity; what was in issue was the way in which he had exercised his statutory discretion. This I readily accept and I apologise if my necessarily summarised report to the GMSC was misleading. The BMA received from the Medical

Protection Society in July 1976 a copy of the writ and statement of claim, but it is now clear that the BMA could not have been told of the amendment to the statement of claim before the trial began.

Four weeks before the trial a letter was received from the MPS seeking a great deal of detailed information, which was readily supplied. The letter also inquired whether, if necessary, a representative of the GMSC would be willing to give evidence in court. In reply it was made clear that, while we would be happy to give evidence in this case, the hearing unfortunately clashed with the Annual Meeting of the BMA in Cardiff. A telephone call was received about five days before the trial saying that it would be of help if someone from the GMSC could appear in court to verify one particular point. The MPS was informed that, although it would not be possible to appear, the chairman or secretary would be prepared to sign an affidavit covering the particular item.

I would like to reiterate that the GMSC will give every support to the Glanvills in their continuing legal actions on this issue, and I hope that any misunderstanding we have had in the past can be put behind us.

TONY KEABLE-ELLIOTT

Chairman,
General Medical Services Committee

British Medical Association,
London WC1

Withdrawal by HJSC from the Review Body

SIR,—We write as representatives of the junior doctors at the Whittington Hospital who met recently to discuss the Hospital Junior Staff Committee's decision to withdraw from the Review Body.

While not in a position to judge the rightness or wrongness of the HJSC's decision, we are concerned that it was not better communicated to the junior staff whom the committee represents. It appears that at present the links between junior hospital doctors and their representatives are inadequate: we feel it is important that these links should be developed and a proper negotiating structure set up.

We wish to record our provisional support for the HJSC as our representative body for the present but with the proviso that under no circumstances would we be prepared to take strike action in view of the harm to patients that would result. We would be interested to know the opinions of other junior doctors on these points.

MARK DENYER

Chairman,
Whittington Hospital Junior Doctors' Executive

SIMON O FRADD

Local representative of the JHDA

Whittington Hospital,
London N19

Clinical medical officers

SIR,—I note that Dr Shelagh Tyrrell's relentless publicity drive for members of her organisation has now been extended to your columns (28 October, p 1233). It is indeed sad that members of the British Medical Association seem to prefer not to attend local meetings where these issues can be discussed and negotiators briefed, but instead prefer to establish splinter organisations which try to establish their national credibility by criticising