(as I think is possible) that productivity has in fact increased and with it work load. Increased throughput in hospitals, earlier discharge, increased patient contacts, minor operations in the surgery, and provision of pathology services by GPs are all evidence of this. In addition, the pressure is now on for a reduction of the working week to 35 hours. Let us make sure that our claims reflect the disparity between this aim and the reality for most doctors, hospital and GP alike.

And, finally (a hobby horse of mine), when will the present ludicrous fee for attendance at a delivery (increasingly accepted as necessary for safe obstetrics) realistically reflect the responsibility, stress, and hours that may be spent on this task?

J F DRACASS

Totton, Hants

Prescribing and family planning

SIR,—The present “brouhaha” for nurses to prescribe the pill has not arisen “from an interpretation of part of the Medicines Act” (Dr N A Chisholm, 21 October, p 1167) but “after pressure from the Royal College of Nursing’s family planning forum” (*Pulse*, 14 October). No doubt this move was prompted before the news filtered through in Britain that the US Food and Drug Administration has made it mandatory since 3 April that contraceptive pills carry a warning label on health hazards and contraindications of usage.

M M O’MEARA

Liverpool

Private practice and the reduction of pay-beds

SIR,—It takes many years for part-time consultants to build up a private practice. They are obliged to earn at least one-fifth of their salary to compensate for the loss of earnings and superannuation. They accept the part-time posts with private facilities available at the State hospitals or in adjacent private hospitals. Some carry out their entire private practice in the State hospitals and have done so for decades. The part-time consultants in this country have been systematically attacked regarding this part of their practice and many of them are totally dependent on the facilities offered by the State hospitals. At these hospitals the cost of the beds has risen astronomically and we have been progressively squeezed out of them, with the result that we are being compelled to find alternative accommodation for our patients. If this continues it will mean that there will be unnecessary duplication of the hospitals and of the facilities that are required, and in certain areas where finances are unavailable it will mean that the consultants will have to relinquish their private work after many years.

Negligible effort has been made to counter this attack on private practice and we think it is about time something was done. The cut-back on beds has been based on occupancy occurring at the worst possible economic time for this country. There has been no statement made that if demand increases the number of beds will be increased. There is no elasticity regarding the number of beds for use despite the fact that emergencies in the acute services are at different levels during the year. We are being attacked, our incomes have been reduced, and we object to it very strongly indeed. Incomes have been whittled down

with no attempt to compensate for losses incurred, which include superannuation. We feel that we should make a stand—if our beds are reduced any more, for every 10% cut there should be a 10% reduction in our overwork.

Is it too much to ask the Central Committee for Hospital Medical Services to consider the part-time consultants’ progressive decline and to make some stand on our behalf?

JOHN J SHIPMAN

K W GILES

A R RYAN

Lister Hospital,
Stevenage, Herts

J M LANCASTER

D R SUTHERLAND

B S SANDHU

I J MCCALLUM

Points

Sympathetic overactivity in tetanus

Dr H HÖRTNAGL (University of Innsbruck, Austria) writes: The potential hazard of using β -adrenoceptor blockers in patients with tetanus has been pointed out (22 July, p 254). The authors concluded that the profound fall in blood pressure, pulmonary oedema, and cardiac arrest that led to the death of a 7-year-old girl were apparently due to propranolol. But it has been reported frequently that in tetanus a syndrome of hypertension may progress to a hypotensive crisis, caused by prolonged sympathetic overactivity, which is often preterminal, does not respond to exogenous catecholamines, and may develop in patients not receiving β -adrenoceptor blockers at all.¹ For the treatment of the overactivity of the sympathetic nervous system in tetanus a combination of β -adrenoceptor blockers and postganglionic adrenergic neurone blocking drugs such as bethanidine should be used.²

¹ Clifton, B, *Lancet*, 1964, **1**, 785.

² Prys-Roberts, C, *et al*, *Lancet*, 1969, **1**, 542.

Scombrototoxic fish poisoning

Dr J P TELLING (Bristol) writes: In August I was requested to visit a husband and wife who said they had food poisoning 45 minutes after eating smoked mackerel. They became covered in a bright red rash on the face, arms, and trunk. Both had one loose motion and vomited twice, with giddiness and a headache. After two hours the rash disappeared and the husband felt better but his wife continued to feel ill with a headache and giddiness which persisted into the night and required a further visit.

Dr R M KUPFER (Wythenshawe Hospital, Manchester) writes: I recently observed an episode of food poisoning that followed immediately after eating smoked mackerel, which had tasted quite normal. The patient developed nausea, followed after 20 minutes by headache, malaise, mild lower abdominal pain, palpitation, and a feeling of intense heat over the face and upper part of the chest, which became bright red. The symptoms gradually resolved over four hours.

Preinjection skin swabbing

Dr J N McARTHUR (Cambridge) writes: With reference to your expert’s paragraph (Any

Questions? 15 July, p 191) and subsequent correspondence.

In 1938 I visited Java and saw the anti-plague campaign of the Pasteur Institute, Bandung, in operation. There were almost two million inoculations each year, done at the rate of 100 an hour. The skin was not cleaned before inoculation, as this had been found useless—there were more abscesses when the skin was washed with methylated spirits, unless this was done thoroughly for 10 minutes as though for an operation.

African travel

Dr W E VAN HEYNINGEN (Sir William Dunn School of Pathology, Oxford) writes: The available antibacterial cholera vaccines for intending travellers in Africa (5 August, p 404; 21 October, p 1160) have some protective value against field-acquired disease, but only for a few months. The protective value of vaccine was demonstrated only in people living in cholera-endemic areas, and appeared to depend on the degree of endemicity. Thus the protection afforded in the Philippines was about half that in Bangladesh¹; and American volunteers receiving vaccine in trials in Baltimore acquired no apparent protection against the disease.²

¹ Benenson, A S, in *Symposium on Cholera, Sapporo 1976*, ed H Fukumi and Y Zinnaka. Tokyo, US-Japan Co-operative Medical Science Program, National Institute of Health, 1977.

² Levine, M, *Transactions of the Royal Society of Tropical Medicine and Hygiene*, 1978, **72**, in press.

Are automatic gear boxes hazardous for driving?

Dr L RENDELL-BAKER (Mount Sinai Medical Center, New York) writes: I fear that the answer to the question (29 July, p 341) about whether automatic gear boxes are more hazardous for driving than manual ones did not address some of the potential problems. Modern automatic transmissions can provide adequate braking for long descents in the mountains almost as well as a manual transmission, but only if the driver is aware of the need to engage “low” and not rely on the vehicle’s brakes. Another hazard not widely appreciated is the ability of an automatic transmission to deliver the full power of the engine with the car stopped should the driver inadvertently step on the accelerator rather than on the brake in a fright or panic situation. With a manual gear box the engine would not respond and would probably stop. I would agree, however, that, generally speaking, an automatic transmission is more restful and imposes less stress on the driver, particularly in towns and traffic.

Treatment of migraine

Mr C COCKBURN (Aberdeen hospitals) writes: I note that Dr D Thrush (7 October, p 1004) makes no mention of correction of refractive errors. It may therefore be taken that in his view provision of spectacles has no place in the treatment of migraine. I could not agree more. Certainly migraine sufferers require visual aids, but as therapeutic agents they are useless. One wonders how many thousands of spectacles each year are prescribed by opticians and others in a vain attempt to prevent attacks. . . .