normal breakfast, before his daily digoxin dose, and after at least 15 minutes' rest. Patients had become familiar with the technique during the period on digoxin prior to this study. Had we measured systolic time intervals in patients whose failure worsened clinically on placebo the influence of changes in ventricular volume, pre-load, after-load, etc, would have been predominant. Although Weissler and Schoenfeld³ found that the effect of a single intravenous dose of deslanoside in patients with severe heart failure was better reflected by the pre-ejection period (PEP) than the left ventricular ejection time (LVET), the indices (PEPI and LVETI) showed equally significant correlations with conventional haemodynamic measurements. Hoeschen and Cuddy,⁴ in patients on maintenance digoxin, found that doubling the dose had no effect on the PEPI but significantly shortened the LVETI.

R J DOBBS

St George's Hospital Medical School,
London SW17

SYLVIA M DOBBS

Middlesex Hospital Medical School,
London W1

W I KENYON

Tameside General Hospital,
Ashton-under-Lyne, Lancs

- ¹ Rogen, A S, *British Medical Journal*, 1943, 1, 694.
² Dobbs, S M, et al, *British Journal of Clinical Pharmacology*, 1977, 4, 327.
³ Weissler, A M, and Schoenfeld, C D, *American Journal of Medical Sciences*, 1970, 259, 4.
⁴ Hoeschen, R J, and Cuddy, T E, *American Journal of Cardiology*, 1975, 35, 469.

Sterilisation reversal requests

SIR,—It was with some interest that I read Mr R M L Winston's article (30 July, p 305). I was fortunate enough in the early 1970s to be able to take the Family Planning Association's training in vasectomy counselling, and up to fairly recently was regularly carrying out this work both for the FPA and on behalf of what was then a local authority. Even though a couple attended a counselling session with a view to the male partner being sterilised, my approach was always that the couple were attending for general sterilisation counselling which covered both male and female sterilisation. A specific method of sterilisation was advised on in detail only after all methods of contraception including sterilisation had been discussed. In my opinion, only by giving a minimum of 40 minutes to each couple and taking this general approach can one even start to attempt to ascertain that sterilisation is the appropriate choice of fertility control at that time and for which partner.

Mr Winston was, I am sure, expressing his concern, among other things, about what appeared with hindsight to be a large number of inappropriate female sterilisations. He admits that his sample was biased, for he gives no idea from what total population of sterilised women his patients were drawn. I would, though, have liked to see him recommend in his final paragraph certain measures which should routinely be adopted, such as I have mentioned in my first paragraph, thus aiming to prevent this particular method of fertility control becoming a target for unjustifiable criticism. I am aware that not everyone will share my view as I have on more than one occasion discussed with members of my profession their belief that sterilisation should be

granted to anyone who requests it, without in-depth counselling.

Even though the technique of sterilisation is a simple procedure, every couple should have the benefit of sufficient time being allocated to them to ensure adequate counselling for what should be one of their most important decisions. This time must be included somewhere in the referral process, be it in general practice, community clinic, or hospital out-patient department. Time spent on counselling is cost-effective when it aims to prevent for a minority a sterilisation which is regretted, but more important when it contributes to the well-being of the majority of patients sterilised.

MARION GILLET

Sheffield

Genital yeast infections

SIR,—I was sceptical when I read of the attempts by Dr R N Thin and others (9 July, p 93) to associate genital yeast infection in women statistically with other sexually transmitted diseases. My colleagues and I¹ found vaginal yeast infections among 18.3% of married and unmarried pregnant women in a study primarily concerned with *Neisseria gonorrhoeae*. In studying the significance of these yeasts during pregnancy the influence of multiple factors was soon apparent. Firstly, the incidence of yeasts is underestimated if cervical rather than vaginal swabs are taken. Secondly, the incidence varies with the stage of gestation, the presence of glycosuria, and the prior use of broad-spectrum antibiotics. The other potent factor, not considered in our pregnancy study but obvious in other work and very relevant to the study of Dr Thin and his colleagues, is the effect of oral contraceptives on vaginal yeast colonisation. It seems more probable that the association of yeast infection with sexually transmitted diseases, though perhaps proved statistically, exists only because sexually active women using oral contraceptives are more likely to have both yeasts and sexually transmitted diseases. Equally so, in sexually active women, the absence of vaginal yeasts does not exclude sexually transmitted disease.

ALLAN B MACLEAN

Department of Midwifery,
Queen Mother's Hospital,
Glasgow

- ¹ Maclean, A B, Paltridge, S, and Platts, W M, *New Zealand Medical Journal*, 1977, 85, 136.

Poisoning with antidepressants

SIR,—The correspondence which has followed the paper by Drs J Park and A T Proudfoot about maprotiline poisoning serves to underline the fact that the most commonly prescribed antidepressant drugs are rather toxic substances. The 323 deaths attributed to tricyclic drugs in 1974 by Dr P Crome and Miss Belinda Newman (23 July, p 260) presumably include cases in which a tricyclic was only one of several potentially lethal drugs ingested. My own method of calculating tricyclic drug deaths gives a lower figure,¹ and I think a fairer one, but it is still disturbing.

Since there is plenty of evidence that antidepressants are too often inappropriately pre-

scribed, it is surely important that the less toxic ones should be preferred. There are two non-tricyclic compounds—mianserin (Bolvidon; Norval) and flupenthixol (Fluanxol)—which appear to have caused no deaths when taken alone in overdosage. Both drugs compare with amitriptyline in their therapeutic effect and mianserin has fewer side effects.^{2,3}

In my view one or other of these drugs ought now to be the antidepressant of first choice in general practice, and even failure to respond ought perhaps to be an occasion for reviewing the diagnosis or seeking specialist advice rather than changing to a tricyclic drug. It is currently regarded as malpractice to use chloramphenicol except for specific indications because safer and equally effective drugs exist. I suggest that the same is becoming true of tricyclics and similar compounds, which cause far more deaths than chloramphenicol ever did.

COLIN BREWER

Birmingham

- ¹ Brewer, C, *British Medical Journal*, 1976, 2, 110.
² Coppen, A, et al, *British Journal of Psychiatry*, 1976, 129, 342.
³ Young, J, et al, *British Medical Journal*, 1976, 1, 1116.

How effective is measles immunisation?

SIR,—Drs M D Coulter and B M Jones (21 May, p 1347) reported their interesting experience of the measles epidemic which affected their practice at Sandy this spring. Six weeks later the same epidemic reached us 80 miles away at Bungay, on the Norfolk-Suffolk border.

In our practice 137 children caught measles. The disease was classically severe, prostrating many children for a few days. Numerous children developed purulent conjunctivitis, otitis media, or bronchitis. In addition two children developed pneumonia, another had a febrile convulsion, and another was markedly ill for several days with purpura. All children were cared for at home. There were five babies under 1 year and a further nine toddlers under 2 years old. The large majority, 114, were aged from 2 to 8 years. After the ninth birthday there was a sharp fall in incidence, with only nine children affected and no school-leavers or adults.

This was the largest measles epidemic in Bungay since we started using the live attenuated vaccine in 1968. For the past 20 years there have been the same four doctors in Bungay: two of us have advocated and performed measles inoculation and the other two have neither advised nor performed it. So I am in an ideal position to answer the question "How effective is measles immunisation?"

I studied the records of the 137 children in the present epidemic. Two had been previously inoculated against measles, the other 135 (98.5%) had not. Of these children, two had suffered a previous recorded attack of measles when they were younger. I also studied the records of 280 consecutive children whom my partner and I had personally inoculated against measles in the past nine years and who had remained in the practice. I found two children (as above) who had developed measles in this epidemic and a third child who had contracted measles in the 1975 outbreak. The other 277 children (99%) have so far escaped the disease. A number of these have suffered several attacks of otitis media or

bronchitis during their lives and I was pleased that they had been protected against measles. The only complication of vaccinating these 280 children was one febrile convulsion. This accords with the reporting to the Committee on Safety of Medicines of 150 cases of convulsion attributed to live attenuated measles vaccine in 3½ years.

In my experience in the past 20 years in this practice measles remains a prostrating and potentially serious illness which recurs in extensive epidemics every two years. It affects almost every child who has not been immunised. In a population with many non-immunised children epidemics will continue. In our summer 1977 epidemic 98.5% of cases occurred in the non-immunised. Measles vaccination is safe, with only one febrile convulsion in 280 children; it confers a high level of immunity, so that of those vaccinated in the past nine years 99% have remained free from measles. As 10% of affected children catch measles under the age of 2 years but none under 6 months, we normally advise vaccination at the age of 13 months.

Before the ravages of further measles epidemics can be curtailed more doctors will need to be convinced of the safety and efficacy of vaccination and fewer mothers frightened by adverse publicity. I hope that our experience will help to convince doctors that in practice measles vaccination is safe and effective and will protect the children under their care.

W M JORDAN

Bungay, Suffolk

Postgraduate training in environmental health

SIR,—The resolution on postgraduate training initiated at the Community Medicine Conference held in Glasgow last month by the West Midlands Regional Committee for Community Medicine is timely (30 July, p 344). In Britain the shortage of medical officers trained and experienced in environmental health becomes increasingly apparent as the holders of the diploma of public health leave the NHS. Facilities for postgraduate training in environmental health are, as the resolution indicates, extremely necessary.

The Post-Graduate Medical School of the Royal Institute of Public Health and Hygiene has a long history of expertise in this field. At the present time the doctors taking the full-time course leading to the DPH examination of the Conjoint Board come mainly, although not exclusively, from overseas. Quite apart from the diploma examination, however, it is apparent that the environmental health subjects dealt with by the institute's authoritative visiting lecturers can be equally relevant to the "proper officer" functions of the doctors practising in the NHS in this country.

The Post-Graduate Medical School of the Royal Institute of Public Health and Hygiene will be only too pleased to be of assistance in the present situation. Inquiries should be addressed to the undersigned.

A D C S CAMERON

Dean,
Post-Graduate Medical School,
Royal Institute of Public
Health and Hygiene

28 Portland Place,
London W1

Need part time be second-rate?

SIR,—As you hint in your leading article (23 July, p 210), there is little evidence to justify an "amateur image" for part-time doctors with domestic commitments or to support a claim that some married women working part time take frequent time off to cope with sick children or "real or manufactured domestic crises." In fact, surveys of married women working part time suggest that they are rather more conscientious and aware of the criticism that they may receive if they do not work well than some of their colleagues. It may be that it is women who are forced to work full time because of the shortage of suitable part-time posts who find themselves with a conflict between their domestic and professional commitments and who sometimes go absent and attract opprobrium.

Otherwise you make admirable and important points. Schemes to train doctors part time have so far been very successful, as one of us has previously described,¹⁻³ but women are now becoming more aware of the difficulties in achieving a part-time consultant post at the end of this period. The suggestions that have been put forward to promote part-time consultant posts are complex and usually unworkable, as we have pointed out before.⁴ Airie⁵ recently summarised the difficulties in an excellent review of the situation and we strongly support your call for a coherent policy for the part-time employment of a large proportion of women doctors doing first-rate work. A recent survey of women doctors by the Royal College of Psychiatrists (to be published) confirms that this is what women want themselves rather than second-rate jobs unwanted by everyone else.

KERRY BUGLASS

Department of Psychiatry,
University of Birmingham

ROBERT BUGLASS

Midland Centre for Forensic
Psychiatry,
All Saints' Hospital,
Birmingham

¹ Buglass, K, in *Women in Medicine*, Proceedings of a Conference, DHSS, July 1975.

² Buglass, K, *British Journal of Psychiatry*, *News and Notes*, November 1975.

³ Buglass, K, Dunn, T L, and Gaston, F W, *British Journal of Medical Education*, 1976, **10**, 297.

⁴ Buglass, K, and Buglass, R, *Lancet*, 1976, **2**, 1202.

⁵ Airie, T, *Lancet*, 1976, **2**, 1073.

Health centre running costs

SIR,—I was distressed to read the letters from Dr C C Griffiths and his colleagues, of Church Stretton (16 July, p 194), and Dr J Gask and his colleagues, of Market Drayton (6 August, p 392), in which they report large unilateral increases of health centre charges which have apparently been deducted from their remuneration without consultation or agreement.

I should like to point out that the General Medical Services Committee had prolonged negotiations with the Department of Health to prevent such occurrences and that a circular, HC(77)8, was sent out to all area health authorities in April 1977. This circular has attached to it a model health centre licence and supporting notes explaining how charges to general practitioners should be negotiated. Firstly, the family practitioner committee must be consulted and has to have written permission from the doctors before charges can be deducted from their remuneration. Where the cost of services—that is, lighting,

heating, cleaning, etc.—is greater than would be incurred by the general practitioners obtaining similar services in their own premises in the vicinity of the centre this latter amount should be the charge. There is also provision for the setting up of a practitioner staff committee, of which every principal is automatically a member, "for the discussion and settlement of matters of common interest to the practitioners—for example, a proposed increase of charges." Further, there is provision for arbitration in the event of unresolved dispute.

I trust that all doctors practising in health centres will scrutinise the above-mentioned circular and will enlist the support of their local medical and family practitioner committees in negotiating a fair deal.

ARNOLD ELLIOTT

Barkingside,
Ilford, Essex

How many medical students?

SIR,—Mr N Scheurmier (6 August, p 392) adopts a most self-righteous attitude to the problem of the future surplus of doctors. I would recommend him to read the leading article in the *Guardian* of 23 April 1976 entitled "Teachers on the Dole"; it was the epitaph of the teaching profession. Is he content to see a similar gloating epitaph written for the medical profession? The dole queue is probably unlikely to affect those of us who have been established as consultants for some time; does Mr Scheurmier expect senior doctors to be silent about such an issue? The recommendation by the Todd Committee to expand undergraduate numbers was based on rather shaky demographic and economic premises. The question now is one of getting sums right rather than creating an élite.

T D BROGAN

Stepping Hill Hospital,
Stockport, Greater Manchester

A gross exaggeration

SIR,—Like Mark Twain in similar circumstances I have to complain of a gross exaggeration. After reading your leading article (6 August, p 347) on "Poor-risk prostatectomy" I hastily checked that my apex beat was still palpable and corneal reflex functioning as of yore, evidence to me, with my archaic concepts, that I am still shuffling around this mortal coil. You had been kind enough to quote me, but dubbed with a surprising prefix.

My dictionary confirms that "the late" refers either to one who is habitually unpunctual or one who is recently deceased. As the former description can rarely if ever have been levelled at me with justice I have to accept the second interpretation, with some chagrin. While I admit to having passed on, or should it be over(?), from working in the fume-drenched atmosphere of a British metropolis to the less polluted air of the Irish countryside, I am pleased to report that I have yet to sample the experiences of the hereafter.

TERENCE MILLIN

Kilcoole, Co Wicklow