should, we first need to earn the money for investment.

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1 McKee M. Poor children in rich countries. *BMJ* 1993;307:1575-6. (18-25 December.)

Healthy alliances with drug dealers

EDITOR,—We wish to report a novel approach to "healthy alliances" in the supply end of the drug market.

A 33 year old man of no fixed abode had a long history of opiate and benzodiazepine dependence. Before his referral he had been in constant contact with his local drugs dealer and had managed, with her help, to switch from injectable heroin to oral methadone. As he could no longer afford to pay for his drugs, however, she suggested that he should refer himself to our community drug team. On presentation he was given a prescription for 30 mg methadone, which he collected daily from his community pharmacist. His progress was complicated by his regular use of top up drugs obtained from his dealer. After four weeks we received the following referral letter from the dealer:

"Mr X has been buying methadone from me on a daily basis. I really do not feel that I should be placed in such a position that I am actually giving him what you should be giving him. I am not a chemist and I also have my own problems. May I express concern for Mr X and his situation. He is of no fixed abode, he is far from being healthy and I feel it is your duty as a caring body of doctors to cater for each patient's needs. Please help this man with his medication before he does something stupid. He needs help and I personally can only do so much. It is your duty to provide his medication not mine. In no way do I mean this letter to be offensive but I have moved to north London and can only care for Mr X as a friend and am no longer able to provide methadone. (signed)"

In response to this letter we increased his prescription to ensure adequate substitute replacement.

It is important to attract drug users into treatment; we hope to be able to receive similar referrals from our local alternative "dispensing colleagues."

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1 Department of Health. *The health of the nation: a consultative document for health in England*. London: HMSO, 1991.

2 Department of Health. *Drug misuse and dependence*. London: HMSO, 1991.

Medical students below the poverty line

EDITOR,—In the recent budget the British government announced that student grants would be reduced by 10% each year for the next three years. This is yet another blow to medical students, who already find themselves in ever worsening financial circumstances.

Students are among the poorest people in Britain. Their income puts them well below the poverty line and yet they are ineligible for most state benefits. Medical students are even worse off: their courses are longer and their vacations—during which students are now expected to earn

money if they can find employment—are shorter. In addition, medical students are expected to spend more on books; travel (because they have more peripheral attachments); equipment (which, being medical, is never cheap); and even clothing (to be appropriately dressed in clinical settings). Banks are now restricting their loans for medical students, and the government student loan for a 45 week clinical year is the same as that for a 30 week standard year (even that is reduced in the final year). Furthermore, not all local education authorities are prepared to pay additional travel expenses. These problems add greatly to the stresses of being a medical student.

Despite repeated protestations by the BMA's medical students committee the Department for Education has failed to recognise the additional financial problems of medical students. With reforms of student unions, the further restriction of grants could be seen as both punishing and gagging the student body. It is shortsighted of the government to reduce investment in education and to make education less accessible to poorer students. Unfortunately, the effects may take some time to become obvious. Medical students are fortunate in having the BMA to represent them, and we would welcome further support from all those who can help us in our campaign.

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Junior doctors' hours

EDITOR,—I wish to correct some misconceptions that may arise from Jesper Poulsen's editorial on the European Union's draft directive on restrictions on hours of work.¹ In neurosurgery, pressure to maintain an 83 hour week comes from both trainees and seniors. This is because continental Europeans are not trained to a standard equivalent to that in Britain.

Britain has an accreditation process that assesses trainees and a system that approves training programmes. Clinical experience is viewed as fundamentally important to training. The system is under continual review, so that recently an examination on the increasing advances in basic science was introduced because of criticism that training had become too clinically oriented.

A British trainee must have operated on over 800 patients to be accredited. In Europe trainees have operated on only 80-120 patients when the certificate of completion of specialist certification is granted. An applicant to our unit who had obtained this certificate in France had operated on only 25 patients. Thus the European certificate of completion of specialist training is in no sense equivalent to accreditation in Britain. A trainee granted this certificate requires a further supervised period before independent practice is possible—that is, he or she is condemned to become a subconsultant.

Evidence exists that long hours on call are necessary to train in a short period. British trainees manage and operate on about 210 patients with trauma before accreditation. Over the past four years British trainees, committed to 83 hours or more each week, have taken five to six years to achieve this level of experience. Clearly, if hours are reduced to 37 a week the time required will be 12 years or more. The effects of this restriction are reflected in the much lower operating figures in most of Europe. European trainers have sent me examples of operating figures for trauma: the average number of patients operated on is only 30 (Switzerland, Sweden, Finland, the Netherlands, and France). A person applying for a consultant post in Britain with a European level of experience would simply not be competitive. The products of

these systems are not consultants and require years of further supervision.

Trainees in Britain are opposed to the creation of subconsultants. I doubt that doctors could be trained in neurosurgery to the level of a consultant in Britain in six years while working only a 72 hours week, and this would certainly be impossible with a 48 or 37 hour week.

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1 Poulsen J. Junior doctors and the EC draft directive on working hours. *BMJ* 1993;307:1159-60. (6 November.)

The contamination of ties

EDITOR,—While Marinko M Biljan and colleagues are right to describe Joseph Lister as the founder of the movement that eventually led to changes in the clothing habits of the medical profession, particularly in the operating theatre,¹ the hoary old myth that "he began to insist, among other measures, on sterilised clothes for operating theatres instead of frock coats and aprons straight off the ward or the street" must be scotched. He did no such thing. Throughout his career as an active surgeon his faith in antiseptics remained undiminished, and he never came to approve of heat sterilisation and the rituals and appurtenances—including the clothing—of asepsis. Thus in the last years of his practice, before operating he "took off his coat, turned off his shirt sleeves, pinned on an ordinary unsterilized huckaback towel over his waistcoat (for his own protection not that of his patient) and washed his hands in 1 to 20 (carbolic) lotion. He wore no mask or gloves."² Special clothes for operating were, essentially, a German invention, with surgeons like Neuber of Kiel being in the vanguard, starting with linen operating coats and caps.³

We can be fairly certain, however, that Lister's tie never fell into his wounds, as published photographs always show him wearing a bow at his neck.²

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1 Biljan MM, Hart CA, Sunderland D, Manasse PR, Kingsland CR. Multicentre randomised double blind crossover trial on contamination of conventional ties and bow ties in routine obstetric and gynaecological practice. *BMJ* 1993;307:1582-4. (18-25 December.)

2 Godlee RJ. *Lord Lister*. London: Macmillan, 1917:460.

3 Neuber G. Zur Technik der aseptischen Wundbehandlung. *Zentralblatt Für Chirurgie* 1892;19:393-401.

An office at last

EDITOR,—After nearly 16 years as a consultant, for most of which I was chairman of my division, and more recently as a clinical director, spending 10-20 hours a week on office work, I have at last been given an office to work in. Is this a record (good or bad)?

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Correction

Management of acute symptomatic hyponatraemia

An editorial error occurred in this letter by Christopher Henegan and colleagues (15 January, p 203). In the table the first footnote should have read "... second bolus of 10 ml [not 30 ml as published] 30% sodium chloride solution."