facts, and to see if such facts are relevant clinically I am astonished to find no less than a leading article in the *BMJ* (10 January, p 55) seeming to ignore these cardinal rules of unbiased objectivity.

When you state that "so much has been achieved that reversal of the trend is unlikely" is this not dogma? In referring to the "persistent belief that selected groups of 'low risk' cases may safely be delivered at home" this is surely allowing bias to creep in. The reference to "a considerable risk to the baby when the mother had to be transferred to hospital late in pregnancy" is putting the cart before the horse. The baby is at risk as a result of the condition necessitating transfer, not because of the transfer itself.

The statement that "deaths from neonatal pneumonia were commoner among babies delivered at home" is a classic example of a quotation becoming misleading when taken out of context. What the National Perinatal Mortality Survey showed¹ was that the overall mortality ratio for hospital bookings was 103, while that for home bookings (irrespective of place of actual confinement) was 88. Also in babies weighing more than 2½ kg there was no significant difference between places of booking, and of pregnancies confined within 38-41 weeks the mortality ratios were similar for hospital and home deliveries (48 for hospital, 47 for home).

I would love to know if Aberdeen women are representative of all British women in height and have yet to see evidence linking minor variations in height with obstetric performance. As for the regional variation in Holland, in the 1972 Confidential Enquiry² maternal mortality was unrelated to the proportion of domiciliary confinements.

I contend that the figures available cannot show a significant difference in safety between hospital and home confinements because like is never compared with like. What is needed is a survey similar to that reported by Dr C A Cox and others (10 January, p 84) but comparing the outcome of a group selected (faults and all) for home booking with that of a matched series of controls booked for hospital confinement. The onus is on the supporters of either side to prove their case and this has yet to be done.

Brevity compels my arguments to be incomplete. I look forward to criticism.

C N BARRY

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¹ Butler, N R, and Bonham, D G, *Perinatal Mortality, First Report of British Perinatal Mortality Survey*. London, Livingstone, 1963.

² Department of Health and Social Security, *Report on Confidential Enquiries into Maternal Deaths in England and Wales 1967-69*. London, HMSO, 1972.

SIR,—If the hospital experts are going to throw bricks we, as general practitioner obstetricians, would appreciate the opportunity to throw a few back.

The article on domiciliary obstetrics by Dr C A Cox and others (10 January, p 84) makes the assumption that all obstetricians and paediatricians consider that all babies should be born in hospital and later refers to the "back to nature" cult of home confinements. We doubt the first premise and consider the second remark highly pejorative.

They mention the clinical errors made by the GP obstetricians. By implication no errors

are made, they would aver, in hospitals. Sadly, we who have worked in both milieux know that this is not the case. Added to this, patients in hospital are inevitably and necessarily treated, and administered to, by junior medical and nursing staff, the results of which can be as or more dangerous than exposure to the domiciliary obstetric team.

Dr Cox and his colleagues mention several reasons why women prefer home confinements. Another is the high level of analgesia given in hospitals, necessitated by the system. We find these high levels generally unnecessary in home deliveries because of efficient psychoprophylaxis. This means that it is rare to have a home-delivered baby needing resuscitation.

Surely, Sir, if some British women wish to have their babies at home as Dr Cox and his colleagues reluctantly concede is the case, and this is certainly our experience, they should be allowed to do so. Those of us who participate in domiciliary obstetrics are convinced of their wisdom and shall continue to ensure that the process can be safely accomplished. We heartily agree with Dr Cox and his colleagues that this should be attempted only in properly selected cases.

Hoddesdon

Broxbourne, Herts

J H GERVIS

R A SUTHERLAND

Effect of junior doctors' action on self-poisoning

SIR,—The increasing incidence of deliberate self-poisoning is now so extensively documented that any record of a decrease must be considered seriously. The "dramatic reduction" of admissions in the first 18 days of December at Kettering and District General Hospital (10 January, p 92) is the more interesting for it coincides with the junior doctors' industrial action. Unfortunately, in Dr G S Crockett's brief report only females were counted and the derivation of the expected number of cases is not clear. As it stands, the difference between the expected (12) and observed (1) cases is highly significant, though it could have been smaller if males as well as the total period of industrial action were to be considered.

Assuming that the admission policy or the definition of an "emergency" in that hospital remained as before the industrial action, and it is indeed stated that all departments were

"adequately covered for 24 hours," what is the likely explanation of this result?

Dr Crockett's view is that the press reports that junior doctors were working a 40-hour week must have created some uncertainty among potential self-poisoners. "One can only conclude," he states, that the knowledge that prompt treatment will be given "plays a large part in the decision of patients to carry out these 'suicidal' gestures, and when this prompt treatment is in some doubt these gestures are not made."

While a reduction in hospital admissions based on such a small sample need not be readily presumed to indicate that the behaviour itself is lessening, it would be of some interest to know whether other parts of the country showed a comparable reduction in acts of self-poisoning. We present below the hospital contacts for self-poisoning in Chichester and Southampton. Not unlike Northants, our population must have been aware of the reports in the mass media, though in none of the four casualty departments included in the survey had the medical cover been restricted during December. Because the junior doctors' dispute was not confined to December we recorded all patient contacts for self-poisoning between 1 September 1975 and 15 January 1976 and focused our attention on four periods of the dispute; and in addition we screened the same periods of time for the preceeding two years. The result (see table) shows conclusively that there was neither any reduction in hospital contacts in general nor a specific sex effect in particular related to the junior doctors' action or its reporting by the press.

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Chromosome damage produced by psoralen and ultraviolet light

SIR,—Psoralen has been known for a number of years to produce lethal and mutagenic effects in a number of widely differing biological systems ranging from bacterial viruses to mammalian cells.¹ These effects are associated with DNA-psoralen photoproducts and interstrand DNA cross-links.² Psoralens plus long-wave ultraviolet light (320-360 nm) are used successfully for the treatment of psoriasis.³⁻⁵ In the course of a series of

Hospital contacts for self-poisoning in Chichester and Southampton in three consecutive years. (Expected numbers based on yearly totals)

Year*	No of contacts	(A) 1 Sept-11 Oct (41 days)			(B) 12 Oct-26 Nov (46 days)			(C) 27 Nov-23 Dec (27 days)			(D) 24 Dec-15 Jan (23 days)		
		M	F	Total	M	F	Total	M	F	Total	M	F	Total
1973-4 (Sept-15 Jan) n = 182	Observed	24	26	50	19	33	52	12	26	38	16	26	42
	Expected	21	33	54	24	37	61	14	22	36	12	19	31
1974-5 (Sept-15 Jan) n = 212	Observed	16	42	58	27	45	72	13	19	32	16	34	50
	Expected	22	42	63	24	47	71	14	28	42	12	23	36
1975-6* (Sept-15 Jan) n = 255	Observed	32	39	71	27	50	77	23	36	59	17	31	48
	Expected	30	47	76	33	52	86	19	31	50	17	26	43

*No industrial action in 1973-74 and 1974-5. In 1975-6: A = free of industrial action; B = sporadic unofficial industrial action; C = official industrial action; D = suspended industrial action.

studies aimed at understanding the molecular mechanism of mutation induction by furocoumarins, of which psoralen is the simplest member of a family of related molecules such as 8-methoxypsoralen and trimethylpsoralen, we have found extensive chromosome damage to be produced in mammalian cells in tissue culture by psoralen and black light.

A simple and effective test for chromosome damage in which micronuclei (chromosome fragments left behind at anaphase) are scored, has been described by Heddle.⁶ The production of micronuclei by physical agents such as x-rays and ultraviolet radiation and by chemical mutagens correlates well with known carcinogenic activity.⁷ In experiments in which Chinese hamster cells in culture were exposed to graded doses of long-wave ultraviolet light (320-360 nm) in the presence of 34.4 µg psoralen per ml of culture medium the proportion of cells showing micronuclei ranged from 6.5% after a dose of 1.34×10^{10} J/m² to 45.2% after a dose of 3.62×10^{10} J/m². These results, indicative of extensive chromosomal damage, suggest that caution be exercised in the use of light therapy combined with psoralens in the treatment of psoriasis as somatic chromosome damage of this magnitude may result, after clonal selection, in later malignancy.

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¹ Igali, S, *et al*, *Mutation Research*, 1970, **9**, 21.

² Cole, R S, *Proceedings of the National Academy of Sciences of the USA*, 1973, **70**, 1064.

³ Weber, G, *British Journal of Dermatology*, 1974, **90**, 317.

⁴ *Medical Post*, 24 December, 1974, p 1.

⁵ Walter, J F, *et al*, *Acta Dermato-venereologica*, 1973, **53**, 469.

⁶ Heddle, J A, *Mutation Research*, 1973, **18**, 187.

⁷ Heddle, J A, personal communications.

Consultant locums

SIR,—I have been an active and strong supporter of the BMA for many years and it is with considerable regret that I find it necessary to write this letter.

In August 1973 I became aware of serious inequities and anomalies in the hospital locum arrangements. To quote only one, the expenses and pension abatement associated with such duties could seriously diminish any income received and in an extreme case could in fact cancel out the earnings altogether.

I wrote in some detail to the chairman and secretary of the Central Committee for Hospital Medical Services and received a courteous and sympathetic reply but no evidence of any positive action. After several more letters from me the CCHMS set up a small working party, with myself as chairman, which met in September 1974 and produced a unanimous report. This was submitted to the CCHMS, which confirmed the report without amendment in November 1974. I understand that the locum problem was referred to the negotiating subcommittee and added to other clauses in the agenda for subsequent negotiations with the Department of Health and Social Security.

Since November 1974 I have written on several occasions to the chairman and secretaries of the appropriate committees and to the chairman of Council, and at all times have received most polite and understanding

replies. What I have not received, or perceived, is any sense of urgency or any sign of positive action which might give a productive result.

As a past chairman of the Superannuation Committee I am well aware of the difficulties associated with negotiations and in particular where major changes and principles are involved. I am also aware of the present problems and the outstanding importance of the hospital staff contract and of independent practice. To add points of detail such as locum terms of service to these matters of principle is most unwise. It can only complicate the issues and seriously delay decisions.

I must also deplore the failure to recognise the degree of urgency in the locum problem. This may not seem vital to men in their fifties, but to retired consultants carrying out locum duties the problem is very different. They have a total working life as a locum of five years (65 to 70) and there has already been two and a half years' delay in achieving any meaningful positive step in the right direction.

What has been required, and still is required, is recognition by the CCHMS and the Negotiating Subcommittee that the matter is urgent, that it is a problem of details and not principles, and that it must not be added to the existing major problems of the Negotiating Subcommittee. A small working team should be set up for this specialised and specific purpose and immediate steps taken to seek a meeting with officers of the DHSS so that the matter can be discussed and the anomalies dealt with.

May I hope at last for some real progress?

R D ROWLANDS

Taunton, Somerset

* * * The Secretary writes: "The report of the Working Party on Consultant Locums was approved in November 1974. In December 1974 the Owen Working Party was dissolved by the Secretary of State and no negotiation was possible for three months. When the dispute was resolved in April 1975 the question of consultant locums' terms of service was agreed as a matter to be pursued together with several reforms to the consultant contract (27 April 1975, p 203). Negotiations had been resumed on these matters when, in July 1975, the Government's strict counterinflation policy imposed a standstill on negotiations which would result in increased income. The CCHMS is to resume these interrupted negotiations as soon as it is possible to do so."

—Ed, *BMJ*.

Doctors' wives and the Sex Discrimination Act

SIR,—May I suggest that all general practitioners who employ their wives as ancillary staff in their surgeries now put in a claim on ANCI to their family practitioner committee for 70% reimbursement of their wives' salaries? It is now illegal, under the Sex Discrimination Act, to discriminate in employment "on grounds of marriage." My husband and his partner are claiming 70% of my salary at the end of the present quarter. If this claim is not paid then they will take the matter to the courts and I hope other GPs will do likewise if necessary.

I am entitled to equal opportunity and expect the same treatment as our other ancillary staff.

I do the same work as our other surgery nurses, and have been doing so since before 1966. After 20 years of working for the NHS for nothing it is about time justice was done. To put it plainly. Working for 10 years as surgery nurse full time at ward sister rates the DHSS have had £21 000 from our practice from my salary. I can earn £3000 per year, but the practice has to pay it all just because I am a wife of one of the partners.

MARY J GLANVILL

Chard, Somerset

* * * We understand that the BMA is already taking legal advice on this matter and it is hoped that a statement on the position will be made shortly.—Ed, *BMJ*.

"Junior hospital doctors"

SIR,—The term "junior hospital doctor" has been widely used by the mass media during the recent negotiations and disputes and it seems a suitable time for us to reconsider the term. It is less than appropriate for a large number of hospital medical staff, particularly the more senior with many years of specialist experience, and it is misleading to patients who may be concerned that a so-called "junior" is deciding their clinical management or performing their operation. Also its recent use by politicians could be construed as being somewhat derogatory in nature.

Before reaching consultant status a hospital doctor will pass through three distinct stages: (1) preregistration; (2) postregistration—before attaining a higher specialist qualification; and (3) qualified specialist. The term "junior hospital doctor" is appropriate for the preregistration year and possibly for some posts after that time but after a specialist qualification has been obtained, with all that this implies, the responsibilities and the standard of patient care provided are no longer consistent with the term "junior doctor." We suggest that just "hospital doctors" would be a preferable collective term for all medical staff below consultant status.

We note that in Ireland there is a financial increment for postgraduate specialist qualifications.

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Whole-time and part-time

SIR,—As we approach 1984 and "newspeak" becomes increasingly the language of the politician it is interesting to see how the concept of "whole-time" and "part-time" has gradually changed. In fact it is not unreasonable to suggest that these terms (as applied to consultants) mean the opposite of what they say.

The "whole-time consultant" (as envisaged by the DHSS) is a part-time doctor. That is to say, his contract specifically excludes him from practising his profession outside his contracted hours and place of work. The