until the patient shows better evidence of intention to co-operate in his treatment. When one operates on this sort of patient, especially through the abdomen, the main morbidity is to the surgeon's coronary arteries, both inter- and postoperatively.

Finally, many surgeons already do refuse to operate on non-co-operative patients. In Mr. Duke's own specialty numbers of orthopaedic surgeons will not do major hip replacements on grossly fat patients. Some vascular surgeons refuse major reconstructive surgery to patients who will not stop smoking. They argue that the effort and expense to the nation involved will, to an extent, be wasted in those patients who continue to indulge in the habit which was the main cause of their disease and will contribute to any failure of their surgery.

In each case, the taking of the medical advice may make the surgery unnecessary.—I am, etc.,

ALAN RHODES

Coventry

Red Skin and Dorbanex

SIR,—Over the past two years we have had four ward patients who developed bright red, sharply demarcated patches of skin either on the inner aspects of the thighs, along the line of the drainage tube of an indwelling catheter, or on the buttocks coinciding with the area of contact with the bedpan rim. In spite of the apparent acute erythema the patients had no symptoms. The patches were characterized by the

irregularity of the edges. The redness gradually faded without trace after the application of a diluted topical steroid. The common factors in all the patients were that they were elderly women, relatively or completely immobile, had had recent urinary tract infections, and had all been taking Dorbanex. There was no other drug common to all.

It is well known that danthron, the synthetic anthroquinone contained in Dorbanex, is excreted in the urine and can cause it to be coloured pink or red. Red staining of the perianal skin and of the buttocks in patients incontinent of faeces has been reported. The red colouration is an "indicator reaction" associated with an alkaline pH and is reversible. If red alkalized Dorbanex is applied to normal skin under occlusion the acid pH of the skin is sufficient to reverse the colour change and no staining occurs. Though the appearance of the lesion was not that of a contact eczema we carried out conventional patch testing with red Dorbanex on the forearm skin of one of the patients with a negative result.

We postulate that for the red staining to occur both an alkaline urine, such as can occur with a urinary infection, and a skin devitalized by friction and some degree of maceration are required. We report these cases as they remained a puzzle to us for a considerable time and might provide a clue to the cause of similar skin lesions in other patients.—We are, etc.,

MARY H. BUNNEY
ISABEL M. NOBLE

Bruntsfield Hospital,
Edinburgh

Review Body Report

SIR,—Apart from the comment that the Review Body Report for 1974 might well have been written by the Health Departments themselves and just as well published on 1 April, I will only draw attention to the abysmal fact of the continuing lack of proper recognition of the senior status of senior hospital medical officers.

It is not merely a matter of experience but of continuing responsibility, as with consultants. Yet they are offered not one penny more than medical assistants, who are of intermediate status and who, like junior medical staff, are eligible for extra duty allowances. A hollow concession is the proposed addition to the S.H.M.O. scale of the two top points of the medical assistant scale, surely a pathetic and meaningless gesture!

Every year that passes sees the perpetuation of this unfortunate anomaly and adds to one's doubts about the Review Body's proper comprehension of the profession's problems.—I am, etc.,

N. V. WILLIAMS

Cefn Mably Hospital,
St. Mellons,
near Cardiff

SIR,—While the fourth Halsbury Report is more encouraging than its predecessors in attitude and understanding, there are still aspects giving rise to great concern. The recommendations show inadequate appre-

ciation of such services as the manpower plight of general practice, the significance here of medical earnings abroad, and the economic value of out-of-hours service. What does shine through successfully above all else is the shortfall in medical earnings of at least 7% since April 1972. This deficiency is greater in general practice and will exceed £1,000 per practitioner. Its effect is that every tenth hour on duty, item of service, house call, etc., remains unpaid for—and earnings-related pensions are reduced in consequence.

While this is no moment to man the barricades amidst the economic blizzard, it is certainly no time for complacency or concessions. We need now to make a firm signal of intent marked in a practical manner. We must withhold agreement on contraceptive services. These are significantly underpriced and it would be foolish in the extreme to extend our services and our contractual obligations when we are both hard-pressed and under-rewarded on our main contract.

Let our aspiring masters put aside procrastination, learn the obligations of "good employers," and settle our multitude of outstanding grievances (they know the list full well). This can usefully occupy the time until phase three restrictions are lifted and pay shortfall corrected; meanwhile the contraceptive services can be repriced by the Review Body given proper support from the Department of Health and Social Security.

While we would all like the family planning issue resolved for many excellent reasons, it would be foolish in the extreme to concede this key, underpriced issue and enter the next round empty-handed with so much at stake.—I am, etc.,

J. G. BALL

Bewdley, Worcs.

SIR,—The Review Body has reviewed. As an unmarried research registrar with inexpensive hospital accommodation and no dependants other than a thirsty motor-car, I have no personal complaint about my own financial status. I am surprised, however, at the paltry increase offered to consultants, and I think many are surprised that their slice was not greater. A government devoted to reducing private practice—a move with which I feel some sympathy—is very successfully increasing the incentive to find supplementary income.

What surprises me most of all is that many general practitioners seem to be under the impression that consultant pay is still the highest in the profession. Presumably this fallacy occurs because many G.P.s see more of those consultants to whom they refer private work. But I believe that a young consultant physician in a teaching hospital has some right to feel faintly jaundiced, if not frankly green, when his senior house officer leaves for general practice to earn considerably more there than the former chief will continue to earn.—I am, etc.,

RICHARD CAMPBELL

University of Sheffield,
Academic Division of Medicine,
Royal Hospital,
Sheffield

SIR,—I have just read that the annual capitation fee for family planning services has been fixed at £1.72. No wonder that the Government has accepted it at once! Having been paid a fee of £5 per annum by the county health committee for those social cases who could not afford family planning services, are we to expect now to be offered only a pittance for these extra services? I for one would not continue to accept a fee which I regard as ludicrous and I trust that it will be rejected by our professional body.

It is time we started to prepare plans for our withdrawal from the N.H.S. It is obvious that the present set-up is not properly financed and that an alternative method will have to be sought. To expect G.P.s to accept 6.5% increase in remuneration and at the same time compete with a 15-18% rate of inflation is a policy of disaster which no self-respecting doctor should be forced to accept.—I am, etc.,

T. D. RICHARDS

Pucklechurch,
near Bristol

SIR,—So we are to receive a derisory 7½% pay rise! At least I can now afford to go to