at work were survived, 20 of the employees concerned being back in their jobs within four months. One can only speculate on how many of the six deaths might have been avoided had special facilities been available at the factory. Women formed only a small part of the work force and they had no known heart attacks during the period of the study. Otherwise the factory population was fairly typical for its size, with 35% of the men in the 45-64 age range but with relatively few in the 65+ group. Turnover rate was 5-6%.

The study showed up differences in incidence between office and shop-floor workers, and the Oxford area as a whole has a low incidence of heart attacks compared with other parts of the country,³ but generalisation on this rather slender basis would suggest between one and two fatal attacks at work per year per 10 000 male employees.

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¹ Joint Working Party, *Journal of the Royal College of Physicians of London*, 1975, 10, 5.

² Baxter, P J, et al, *British Journal of Industrial Medicine*, 1976, 33, 1.

³ Kinlen, L J, *British Heart Journal*, 1973, 35, 616.

Requests for references

SIR,—I endorse the letter from Dr T B Boulton (24 July, p 236) on ill-mannered requests from health authorities for references for medical appointments.

This week I received a request from the North Yorkshire Health Authority which was not signed at all. It consisted of a form and an envelope addressed to an anonymous district administrator. Neither the form nor the envelope was marked "confidential." The devaluation of a professional training was evident from the form. In descending order of importance I was asked to comment on the candidate's character, initiative, drive, leadership, management ability and potential, professional ability, and capacity for getting on with people.

I suggest that ethical considerations would be met if references were sent only to the consultants concerned and fatuous forms ignored.

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Dextropropoxyphene poisoning

SIR,—We were interested to read the letter by Drs D J L and E D Carson (10 July, p 105) regarding death following the ingestion of analgesic preparations containing dextropropoxyphene. We agree with these authors that the potentially serious danger of acute respiratory depression is often forgotten in patients poisoned with this drug. Equally, many doctors fail to realise that the most commonly prescribed combination of an analgesic and dextropropoxyphene (Distalgic) also contains paracetamol and therefore do not anticipate the hepatotoxic effects which may ensue.

Between 1970 and 1974 approximately 28% of the deaths from paracetamol poisoning in the United Kingdom were in those who had ingested a dextropropoxyphene-paracetamol mixture.¹ A detailed analysis of 1369 cases of paracetamol poisoning reported to the London centre of the Poisons Information Service between January 1975 and June 1976 indicates that 35 of these patients died. Paracetamol alone was responsible in 29 cases; dextropropoxyphene in 4 cases; while other drugs were the cause in the remaining 2 cases.

We believe that the letter from Drs D L and E D Carson is a timely reminder of the potential seriousness of a dextropropoxyphene overdose. May we therefore emphasise that naloxone is a safe and specific antagonist for dextropropoxyphene²⁻⁴ which should be administered—to symptomatic patients—as soon as possible after ingestion. Repeated doses of this antidote may, however, be required as the duration of action of dextropropoxyphene exceeds that of naloxone.

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¹ Volans, G N, *Journal of International Medical Research*, 1976, 4, Supplement (4), 7.

² Kersh, E S, *Chest*, 1973, 63, 112.

³ Tarala, R, and Forrest, J A H, *British Medical Journal*, 1973, 2, 550.

⁴ Lovejoy, F H, Jr, et al, *Journal of Pediatrics*, 1974, 85, 98.

Diagnostician of the year

SIR,—If there was an annual distinction awarded by the Royal College of Physicians of London for the title of "Diagnostician of the year" surely the award for 1976 should go to the laudably obdurate mother of the family discussed in your report of the Clinicopathological Conference (31 July, p 285). She sequentially correctly diagnosed her husband's complaint, then her own, and then her son's—all diagnoses apparently at variance with the original opinions of the experts of the medical entourage.

MAX HONIGSBERGER

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Contract dispute

SIR,—I wish to comment on your leading article (24 July, p 201) and the reports of meetings held to discuss the juniors' contract dispute (24 July, p 254). The fact that perhaps 60% of health authorities have already been paying juniors on the basis that they are entitled to regular overtime payments (for that is what they are) while they are on leave, and in addition paying them for covering the absence on leave of colleagues, does not make such an arrangement permissible under the contract arrangements as agreed between junior doctors' representatives and the DHSS and issued to health authorities. The amount of work performed for a doctor by other colleagues when he is on leave exactly matches the additional amount that he will be required to perform when they are on leave, in a properly constructed prospective contract.

Where such contracted income is paid in equal amounts over 52 weeks it does meet Dr

Wardle's criterion on which, he says, that the original agreement was made, namely, that the "new contract contains contractual payments for additional work; these continue during holidays and study leave and can easily be used for mortgage." It is Dr Wardle's misunderstanding of his own quotation which is the cause of the whole problem and which is why I refer to UMTs paid over and above the standard working week as "over-time." These payments are, as Dr Wardle says, "for additional work." I submit that additional work cannot be performed when a doctor is on leave, so that when he is on leave his entitlement for payment for additional work ceases, so that where an authority pays him for this unperformed work it must be matched by an equivalent amount of additional work performed, and this is what he does when his colleagues on the same rota are on leave in their turn.

The number of contracted units has been further confused by quite irrelevant matters such as notional assessments for flexibility and secretarial work and the inaccurate assumption that the more doctors there are on a rota the more UMTs need to be contracted for in order to cover the additional work occasioned by their absence on leave. The junior doctors' representatives are not alone in misunderstanding their contract, but as an officer of an authority which understood the full and ominous implications of the new contract from the start—gleaned only from the same information available to everyone else—I feel bound to protest at these belated and unfounded expressions of horror and betrayal.

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Armchair theorists

SIR,—The interview with Mr Alan Fisher (24 July, p 227) deserves comment. His undoubtedly sincere views confirm what many of us have been saying for a long time, namely, that NUPE's and other union's statements about the Health Service are based either on ignorance or on misunderstanding of the facts. The reasons are not far to seek because, as with Department of Health officials, they have no practical experience of what really goes on in our hospitals.

According to Mr Fisher phasing out of private beds is a moral issue. I have no quarrel with this view, but I would ask him if he would agree that unilaterally breaking of a consultant's contract is also a moral issue. I doubt if union members would accept this treatment.

He goes on to repeat the same old fantasy about people being allowed to use NHS facilities to carry on their private practice. As with others who make this statement, he fails to produce any evidence that this is the normal practice in our hospitals. My colleagues and I perform operations in a private operating theatre situated in a building which is attached to, but in all other respects separate from, an NHS hospital, using nurses not employed by the NHS. This theatre is used regularly for NHS patients when the one in the main hospital is either out of action or fully occupied. He obviously does not appreciate this facility would no longer be available for NHS patients when private facilities are phased out.