and presumably by different people. The study we have referred to, carried out by one investigator, avoided this criticism by using paired data from the same patients and this may explain the contrasting results. Also it is possible that sampling the skin immediately after shaving gives rise to the very high counts which were noted in the data we present owing to the exposure of viable organisms from the deep layers of the skin. Certainly our evidence would not support a policy of shaving the operation site immediately before surgery, and more evidence is needed before this becomes widely adopted. Perhaps the answer lies in abandoning the practice of preoperative shaving and using depilatory creams. The results of Mr Powis and his colleagues and of previous work[5] certainly support this suggestion.

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[1] Altemeier, W A, in *Infection in Hospitals: Epidemiology and Control*, ed R E O Williams and R A Shooter, p 207. Oxford, Blackwell, 1963.
[2] Bocock, E J, and Parker, M J, *Microbiology for Nurses*, 4th edn, p 168. London, Baillière Tindall, 1972.
[3] Williams, R E O, *et al*, *Hospital Infection*, p 224. London, Lloyd-Luke, 1966.
[4] Parker, M J, *Contact*, 1973, p 13.
[5] Seropian, R, and Reynolds, B M, *American Journal of Surgery*, 1971, **121**, 251.
[6] Linton, J, *Nursing Times*, 1974, **70**, suppl, pp 33, 37, and 41.

Antibiotic use in general practice

SIR,—Dr J G R Howie's conclusions from his study (30 October, p 1061) are interesting and might perhaps be paraphrased as showing that the doctors did not rate antibiotics highly in the treatment of sore throat and that they were prepared to give the patient the benefit of the doubt if there were sufficient reasons to do so. The usual reasons seemed to be that there was an important engagement in the near future or the patient was already under stress before the illness started.

It seems to me from studying the figures that apart from these two considerations (that is, excluding patients B7-12) there was remarkable consistency in the rate of antibiotic prescribing by the doctors: nearly all the figures lie between 22% and 44% of doctors, and I believe that this is not a significant difference. It would seem therefore that the appearance of the throat does not affect the rate of prescribing.

Can Dr Howie tell us from his data whether selection of cases for antibiotic treatment is random by individual doctors or whether doctors prescribe as individuals consistently frequently or consistently infrequently?

J B METCALFE

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**We sent a copy of this letter to Dr Howie, whose reply is printed below.—ED, *BMJ*.

SIR,—Dr Metcalfe is right to look at the influence of doctor-behaviour on prescribing. There were indeed, as stated in the paper, doctors who prescribed antibiotics for all patients or for none of the patients and the distribution of range of individual doctors was closely similar to that previously reported in a study involving doctors recording details of patients seen in their own practices.[1]

The illustrations used in the study to which Dr Metcalfe refers were selected because they appeared to represent the type of throat abnormality over which there is the maximum of present disagreement on prescribing. The fact that most of the figures in the "A" group of patients fell within the range 22%-44% was thus expected. However, at one extreme the abnormality presented proved bad enough to make 93% of doctors decide an antibiotic would be necessary, confirming that there are, of course, occasions when appearance is the main consideration determining treatment.

The short answer to Dr Metcalfe is that the appearance of the throat is important beyond a certain level of abnormality but that below this point all points on the prescribing spectrum are represented, from doctors who prescribe consistently highly, through those whose prescribing patterns *appear* random, to those who prescribe consistently infrequently. The findings of this study have suggested that patient characteristics of a non-physical nature are yet another potential influence on prescribing habits.

J G R HOWIE

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[1] Howie, J G R, *Journal of the Royal College of General Practitioners*, 1973, **23**, 895.

Sectional strife

SIR,—I am sad and dismayed every time I pick up the medical journals these days as I read one pundit after another denigrating some section of the profession's activity and, in the name of economic necessity, proclaiming that we can do without that section or cut its activity to the bone.

Over the past few weeks I have read that we need to cut down the money to our "centres of excellence" so that a fairer share of the financial cake may go to the outlying areas. Then the general practitioners are attacked, both for their prescribing habits, their sinful alacrity to delegate after they have been driven by financial incentives into impersonal health centres and enormous group practices, and their failure to give a preventive medical service in between, I presume, their 5-min consultation times. Then the junior hospital doctors are attacked for their ruthless devotion to cash, which has ruined the cash differential between consultants and themselves and thereby emptied the country of any applicants for consultant posts.

The list is endless as each section of the medical community, in despair at the disintegration of its own area of care, blames it on some other section of his profession. The situation is desperate because no one seems to realise that the fault for the economic crisis in the NHS is not ours but is due to the 300% increase in administrators while the overall increase in medical staffing is less than 10%. The population has not increased by 300% so we have roughly the same number of people to look after; thus the crisis is entirely due to overspending on administration, to what purpose?

As a profession we must stop pontificating on one or other section of medicine, which delights the administrators and gives them the ammunition for endless cuts to the "doers" of this profession while allowing them to extend their own empires. Let us have a truce, let us analyse the others, and let our harassed colleagues get on with their work without any more well-meaning but devastating surveys/studies/critiques of our profession's work. When the administrators have been analysed and decimated then let us start to rebuild, not criticise, our NHS.

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JHDA

SIR,—May I add my experience to that of Dr R A V Milsted (4 December, p 1391)? During four years in the BMA I have not once received notice of a BMA meeting to elect officers or delegates.

Perhaps if there were no feud between the Hospital Junior Staffs Committee and the Junior Hospital Doctors Association a higher level of interest in representation in the regions would prevent this state of affairs. I do not think this is possible at present. A fundamental difference between the two organisations was pointed up by HJSC officials in a recent letter to you (6 November, p 1136), when they indicated that consideration of the interests of one section of the profession should be subject to those of the others. The JHDA, however, makes no prior commitment on this, for that does not preclude an "adult relationship" between sections of the profession.

But can this difference of opinion be contained by the BMA framework? Doctors who, like Dr Milsted, are more than ready to participate in democratic medical politics should badger their organisations by asking them precisely the questions he asks of Dr Elinor Kapp.

J R SAMPSON

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Junior Members Forum

SIR,—May I make use of your columns to draw attention to the Junior Members Forum 1977? It is planned to hold this in the University of Newcastle upon Tyne during the weekend of 2 and 3 April. As usual, the meeting will have two phases. During the scientific part the subject will be "Positive health—idealism or realism?" which should afford opportunities to discuss the problems and possibilities of preventive medicine and health education. The second part will allow the forum to discuss matters of current and future importance to the profession and affords a chance to influence the policy of the Association.

However, it is hoped that, once again, an invaluable feature of the weekend will be the informal contacts and discussion arising with other members of the forum. Anyone interested in attending should contact their divisional secretary or, in the case of hospital junior staff, the honorary secretary of the Regional Hospital Junior Staffs Committee.

DAVID BELL
Chairman,
Junior Members Forum 1977

BMA Scottish Office,
Edinburgh