gave her indigestion it was stopped after six days. She is now on Minovlar (norethisterone 1 mg. and ethinyl oestradiol 0·05 mg.) and her weight is steady at 10 st. 7 lb. (66·6 kg.), and her blood pressure is 130/75. She is not on a diuretic.

A similar but more serious case has also been treated at Guy's and is shortly to be published (Dr. P. W. R. Harris—personal communication), and one wonders whether perhaps this is a rather more common side-effect of oral contraception than was hitherto expected.

I would like to thank Dr. G. Scott and the West London branch of the Family Planning Association for permission to publish the clinical findings on this case.

—I am, etc.,

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Treating Shock

SIR,—We agree with Dr. N. McE. Lamont and Dr. K. Posel (12 July, p. 116) that it is important to maintain an adequate central venous pressure in acute circulatory failure, and should like to point out that we did not, as they suggest, overlook this principle in administering phenoxybenzamine to the patient discussed by them.

When comparing central venous pressure measurements by different authors it is essential to allow for differences in the zero reference point. The article by MacLean *et al.*,[1] quoted by Drs. Lamont and Posel as showing the normal central venous pressure to be between 5 and 11 cm. water, makes no mention of their reference point (nor, incidentally, of "normal" values), which may, however, be taken on the basis of information given elsewhere[2] to be 5 cm. below the sternal angle in a supine patient. We have taken the sternal angle itself, as stated in our article, so that a central venous pressure of +6 cm. corresponds to a value of +11 cm. with reference to MacLean's zero, and this value, in a patient with a low cardiac output and severe pulmonary oedema, does not contraindicate a trial of vasodilator therapy.

The effect of phenoxybenzamine on the central venous pressure is variable and cannot be predicted with certainty. We agree that if it falls to low levels without a rise in cardiac output, then it should be restored with intravenous fluid. An infusion raised the central venous pressure in our case to +8 cm. (or +13 cm. relative to MacLean's zero) where it remained unaffected by more phenoxybenzamine.

We presume that the statement "A central venous pressure lower than 5 cm. H_2O is normally regarded as indicative of hypovolaemia . . ." is meant to apply only to low cardiac output states. A central venous pressure about this level, or even lower, may be associated with a good cardiac output and require no interference,[3] as illustrated in Fig. 4 of the article now under discussion.[4]—We are, etc.,

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New Cross Hospital,
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"Mediflash"

SIR,—I should like to express my thanks to the Mediflash and the Lancashire police whose motor-cyclist saw my Mediflash and led me, with his siren going, past an eight-mile traffic queue from Ormskirk to Southport to do an urgent forceps delivery with successful outcome on a Sunday afternoon.

As a busy obstetrician working at the "periphery," I have often had to use my Mediflash to negotiate holiday traffic jams and cannot speak too highly of its usefulness and praise the public and police enough in their invaluable co-operation when they notice it.—I am, etc.,

COLIN R. PORTEOUS.

Ormskirk, Lancs.

Doctors and Overtime Pay

SIR,—While the whole profession agrees that payment for extra duties is overdue for hospital junior staff, I cannot understand why this should not apply to all medical staff, including consultants.

When the idea of sessions was first applied to hospital work-load the consultant was a person who truly consulted and acted in such a capacity during normal working hours. Since those early days many consultants, especially in the smaller hospitals, have become so involved in the day-to-day working of the hospital that their hours of responsibility and labour have extended to cover a full 24-hour day, not just as a nominal cover but as one closely involved with an emergency rota and without the services of a registrar.

It should be the aim of the Health Service to form units on a regional basis so that the work of consultants will be limited to a time-factor approaching the sessions for which they are paid. This will necessitate eliminating full emergency services in the smaller hospitals. Where this is not done then those consultants who are genuinely available for emergency duties, especially in surgery, anaesthetics, and obstetrics, without the intervention of a competent registrar, should be adequately compensated for these additional commitments. Again, where locum cover is not provided for such a consultant when on leave, and where this can be shown to throw additional work on a colleague, then the latter is entitled to adequate compensation.

However, the main objective should be to trim the hours of work, including time on-call, to a figure which allows a person to lead a normal life with adequate free-time. These points should be included in the submission for consideration by the Review Body.—I am, etc.,

JAMES BLUNDELL.

Bessbrook,
Co. Armagh.

The Consultant's Job

SIR,—The regional consultants are acutely aware that they have been badly let down by the issue of a document (*Responsibility of the Consultant Grade*[1]) by a committee on which they were not adequately represented. For instance, our regional consultants and specialists association president, Mr. Donald Young, was ignored. With the emergence of a militant feeling from my fellow consultants, who associate themselves with my views, I should like to make the following points:

(1) The regional consultants will not be the "scapegoats" to cope with the problems of too many juniors keen on medicine and surgery. It is emphasized that there are advertised in the journals a large number of consultant posts that cannot be filled (200).

(2) They will not be diluted or demoted. Their work conditions and income are already at low ebb.

(3) They will maintain their junior staffs which are mainly from abroad so that they can pass on some of their extensive practical experience. If our registrar numbers are to be reduced then the reduction should be where the excess lies and the amount of practical training is minimal. This occurs in the undergraduate and postgraduate schools, three senior registrars and five registrars for every ten consultants compared with the regional hospital staffs—that is, three registrars and a half a senior registrar for every ten consultants.

(4) They insist that when they are otherwise engaged State patients are looked after by experienced juniors, not by those recently qualified. This adequate care is owed to the patients.

(5) They insist that if general practitioners are intent on doing consultant work, or acting as a specialized junior staff (for which they receive double pay), they should be compelled to receive adequate and proper training as envisaged by the colleges. It is noted that the general practitioners describe themselves as being overworked; accordingly it does not leave them much time for hospital work.

(6) The regional consultants have been trained and have participated in the training of the junior staffs at undergraduate hospitals. They therefore insist that they have a right to continue this training as being part of the training scheme.

(7) They insist, as a majority group, on taking their rightful part on the various committees which include those of the colleges.

(8) Research monies and building, medical, technical assistant, and secretarial staff to aid research in the regional hospitals should now be made readily available.

(9) Private accommodation anomalously pruned recently in the regional hospitals should be re-instituted and improved to attract suitable doctors to specialize in the regional hospitals.

To summarize—an increasing slice of the "National Health cake" is being consumed centrally in staffs, research moneys, and awards. Following the lead of our vociferous junior staffs it is now our turn to publish the facts and insist at least on maintaining