a recollection of one of Miss Nightingale's aphorisms: "Bad administrative arrangements often make it impossible to nurse."¹—I am, etc.,

PEGGY NUTTALL
Editor,
Nursing Times

London W.C.2

¹ Florence Nightingale, *Notes on Nursing: What it is, and What it is Not*, London, Harrison and Sons [1859].

Recent Research into Psoriasis

SIR,—I was interested to read the review on recent research into psoriasis (24 July, pp. 231 and 234), in which Professor S. Shuster states that although the dermis plays an important role in epidermal differentiation this aspect has received little or no attention in psoriasis. Preliminary investigations on the Koebner reaction in psoriatic subjects using dermal extracts¹ suggested the presence of a factor in the dermis of active lesions and uninvolved skin of the active patient which has a stimulant action. This factor did not appear to be present in normal non-psoriatic dermis.—I am, etc.,

L. STANKLER

Aberdeen Royal Infirmary,
Aberdeen

¹ Stankler, L., *British Journal of Dermatology*, 1969, **81**, 207.

Cerebral Vasodilators

SIR,—Dr. C. G. Elliott (17 July, p. 185), commenting on cerebral vasodilator drugs, inquires whether or not such drugs have been given early in the course of cerebrovascular disease.

We have just completed work in this department where cyclandelate (Cyclospasmol) has been given to elderly patients in good health in their own homes. These patients appeared mentally normal in conversation but, on psychometric testing, had early intellectual impairment. Cyclandelate was used in a double-blind crossover trial and statistically significant improvement in the mental function occurred with the drug. The detailed results of this trial will be published later.—I am, etc.,

T. G. JUDGE

Department of Geriatric Medicine,
Stobhill General Hospital,
Glasgow N.1

Gaps in Venereology

SIR,—The letter from my former colleagues Drs. F. M. Lanigan-O'Keeffe and W. Fowler (17 July, p. 184) is becoming a hardy perennial but is none the less timely for that and deserves support.

The centripetal collapse of the V.D. services will be fascinating to watch. Apart from there being no newcomers to learn the specialty now, there will shortly be no one left to teach, for those now in harness shall surely all die or retire.

The profession and its administrators must awaken to the fact that there are major specialties and minor specialties, popular ones and less popular ones, lucrative and otherwise. Unsuccessful candidates for the major and popular and lucrative branches of medicine and surgery (same thing), many with three or more years experience as registrars behind them and with higher

degrees in medicine, surgery, or obstetrics and gynaecology, should not only be enticed but should also be considered acceptable and even desirable candidates for senior registrar posts in the minor specialties, without the purblind insistence by effete committees upon their doing a further year or more, still at registrar level, before being thus considered.

You think this opinion is based on hypothesis?—I am, etc.,

A. S. WIGFIELD

Newcastle General Hospital,
Newcastle upon Tyne

Double Distinction

SIR,—I read with interest the medical memoranda on dystrophia myotonica presenting with dysphagia (22 May, p. 443). The paper confirms our more recent impression that dysphagia is not uncommon in advanced cases of dystrophia myotonica, and it is not necessarily seen in the terminal stages of the illness.

I note that *Punch* in a recent parody (9 June, p. 778) on the *B.M.J.* has selected part of this paper for its spread, and has quoted our book (Caughey and Myrianthopoulos).¹ This is a rather nice distinction; to attempt a serious monograph and then to find it takes a mention in the humorous columns of *Punch*. What would you do about it?—I am, etc.,

J. E. CAUGHEY

National Iranian Oil Company Hospital,
Abadan, Iran

¹ Caughey J. E., and Myrianthopoulos, N. C., *Dystrophia Myotonica and Related Disorders*, Illinois, Thomas, 1963.

False Positive Tests for Abnormal Haemoglobins

SIR,—The Sickledex (Ortho) test for the detection of haemoglobin S is a convenient and speedy method for the screening of patients suffering from sickle cell disease (homozygous haemoglobin S) or the sickle cell trait (heterozygous haemoglobin A S). Reliability has been impressive as shown by several authors¹⁻³ who, in over 1,000 cases, failed to demonstrate a false positive result. Diggs *et al.*,¹ however, also state that false positive results are seen in some cases of dysproteinemia, such as myelomatosis, with high plasma levels of gamma globulin. They suggest that distinction can be made between the flocculation seen in this situation and that seen in the presence of haemoglobin S.

Recently, however, we have found a positive test in a 42-year-old Tanzanian male, who was shown subsequently by cellulose acetate electrophoresis to have only haemoglobin A present. His metabisulphite test was negative. He presented with acute abdominal pain, with a haemoglobin of 7.0 g/100 ml (thus necessitating the addition of 0.4 ml of peripheral blood to the test solution). Eventually he was shown to be in renal failure, and this prompted us to test a number of routine specimens received from cases of chronic renal failure, and later other cases of profound anaemia.

Out of 22 samples tested six gave positive results. So far four of these samples have been re-examined with the cells washed and resuspended in isotonic saline. In all cases the test was then negative. To minimize the chance of observer error these tests were

done in duplicate in two separate laboratories, and on these four cases haemoglobin electrophoresis showed haemoglobin A only. Abnormal proteins have not been demonstrated in these patients but all were anaemic (haemoglobin less than 7.0 g/100 ml), and therefore 0.4 ml of blood was added to the test.

Further studies are being done to confirm these observations. The cause of the false positive results is not entirely clear, but our preliminary tests indicate that it is associated with anaemic patients and the necessity of adding 0.4 ml of blood to the test solution. It seems to us, therefore, that false positive reactions do occur and may provide an erroneous diagnosis if this fact is not appreciated.

We would like to thank Mr. C. K. Campbell of Ortho Diagnostics for his help and generous supplies of Sickledex.

—We are, etc.,

J. S. LILLEYMAN
T. BILLS

Department of Haematology,
Royal Infirmary,
Sheffield

¹ Diggs, L. W., Schorr, J. B., Arcari, W. O., and Reiss, A., 1968. In *Proceedings of the 23rd Joint Annual Meeting of the American Society of Clinical Pathology and College of American Pathologists*.

² Canning, D. M., and Huntsman, R. G., *Journal of Clinical Pathology*, 1970, **23**, 737.

³ Loh, W. P., *Journal of Indiana State Medical Association*, 1968, **61**, 1651.

Status of Radiology in Britain

SIR,—In the past few years a great deal has been written on this topic in the general medical press. The comments seem to be unanimous in stressing the inadequate provision and lack of academic departments in radiology in this country.¹ In the light of some discussions at a meeting a year ago, our deficiencies became very obvious.² An editorial in *Radiology*³ clearly stresses and highlights the deficiencies in academic departments in diagnostic radiology in Britain.

To quote but one point from this editorial: "The slowness and lack of recognition of the great potential in radiology in teaching and research have had bad effects on the status of British radiology and have hampered the quality of British medical schools."

Having recognized our deficiencies and having the facts so clearly stated, what can be done about it? The present state of affairs of inadequate provision of academic departments in radiology cannot continue indefinitely if the specialty is not to suffer further and irrevocably. The deleterious effect on recruitment, teaching and research,⁴ and even routine services can no longer be denied. For instance, the intake of trainee radiologists in the United States before the widespread creation of new academic departments was relatively low, but the demand is now so great that numbers may well have to be limited and last year approximately 11% of graduate students showed an interest in radiology, intending to specialize in this field. There is little doubt that this success story could be repeated in Britain if we only had the means to do so, but so long as we are housed, staffed, and equipped the way we are at the moment such developments are totally Utopian and quite out of our reach.

We can only hope that our universities and medical schools in particular will recog-

nize these deficiencies, and that they will press very hard for the development of academic departments in the next quinquennium. Once the demands from the medical schools have been recognized the University Grants Committee will have to act, and we can then hope for an adequate response from the Treasury and Government. In the meantime, it is up to the heads of the profession to sustain the pressure and reiterate our case vigorously on all suitable occasions.—I am, etc.,

R. E. STEINER

Warden of the Fellowship of the
Faculty of Radiologists

London W.12

¹ Bull, J., *Proceedings of the Royal Society of Medicine*, 1970, **63**, 835.

² Margulis, A. R., and Steiner, R. E., *British Journal of Radiology*, 1970, **43**, 833.

³ Margulis, A. R., *Radiology*, 1971, **100**, 187.

⁴ Samuel, E., *Clinical Radiology*, 1971, **22**, 3, 288.

Prescribing of Thyroxine

SIR,—There are a number of drugs which are often prescribed in more frequent doses than is necessary. Thyroxine is probably the best and commonest example of a drug subjected to such polydosage. I have regularly seen patients who have been advised to take their thyroxine in divided doses, and one elderly lady was fumbling through 0.05 mg q.d.s.

Thyroxine is one of the slowest acting agents we use and its metabolic effects last for weeks. The suitability of a once daily dose regimen was amply justified in an article in your series "Today's Drugs" (31 May, 1969, p. 561). I was, therefore, disappointed by the recommendation in a recent article in the same series (26 June, p. 760) that thyroxine should be given in divided doses. If thyroxine is given in divided doses it makes the patient's life a little more complicated and suggests that the prescriber is unaware of the properties of this drug.—I am, etc.,

J. H. WETHERILL

Staincliffe General Hospital,
Dewsbury, Yorks

Medical Charities Collection

SIR,—I should be grateful for the courtesy of your columns to thank the Representatives at the A.R.M. at Leicester last month for their splendid response to the collection in aid of Medical Charities, which produced the greatly appreciated total of £162.10.—I am, etc.,

R. COVE SMITH

Chairman, Charities Committee

London W.9

Payment for Overtime

SIR,—My attention has been drawn to the plight of hospital junior resident doctors who are afraid to claim overtime pay knowing that the consultants under whom they work are opposed to the principle. Rather than risk receiving an uncomplimentary testimonial at the end of their appointment, they forgo their rightful remuneration which may amount to as much as £500 per annum or more.

Some of the consultants concerned may be unaware of this situation, and my pur-

pose in writing is to remind them that, knowing that their juniors do work overtime, they should make a positive effort to ensure that they are presented with the application form for signature each month. Failure to do so represents a form of negative blackmail, which in the end will do far more harm to medical prestige than the receipt of payment for long hours of work well done.—I am, etc.,

IAN G. WICKES

Stock, Essex

SIR,—Regarding extra duty allowances for hospital junior doctors, I should like to bring attention to one unjust anomaly in the system—namely, that the same allowance is granted, whether or not the doctor is compulsorily resident while on duty. Thus, a registrar on nominal call every night in a quiet unit can claim almost £200 per month before tax, without ever being called, while a registrar, compulsorily resident every second night and weekend, actively working a large proportion of the time, can claim no extra duty allowance at all.

While disagreeing strongly with the principle of overtime in the medical profession I contend that the system as it is run presently fails to help the very people for whom it was devised.—I am, etc.,

ROY G. CONDIE

Department of Obstetrics and Gynaecology,
University of Dundee

Salaries in Public Health

SIR,—From time to time, I read with interest Dr. C. D. L. Lycett's reported comments as chairman of the Public Health Committee of the B.M.A. One realizes the great efforts being made to safeguard and protect the future career of public health doctors in any reorganization, but I feel that I should draw attention to one very good reason why the public health field has lost experienced D.P.H. holders from its service. Apart from the obvious financial attractions to general practice, those still wishing a career in medical administration can easily transfer over to regional hospital board appointments with substantial increases in salary.

Examination of the appointments advertisement section of the *B.M.J.* illustrates at regular intervals that assistant senior M.O. posts in regional hospital boards have a much higher average salary than public health assistant senior M.O., senior M.O., principal M.O., or even deputy medical officer of health posts, unless the latter is with a large county borough or county council. It may be that such cross-fertilization is a good thing, but should it be one way—public health authority to regional hospital board?

It is really urgent that agreement be reached at Whitley Council level that these posts be jointly reviewed so that a depleted public health service be at least maintained until 1974.—I am, etc.,

WILFRID H. PARRY

City of Nottingham Health Services,
Nottingham

Pensions in the N.H.S.

SIR,—The conference of Local Medical Committees is to be congratulated on its resolution to press for the removal of the abatement rule in respect of pensions taken

before the age of 60 years (*Supplement*, 3 July, p. 18). This rule strikes hardest at doctors forced into retirement through disability and who subsequently have been able to take up less remunerative work within the compass of their disablement.

Take, for instance, a general practitioner forced to retire in 1967 with a pension of £750 a year and maximum permissible earnings from public funds plus pension £3,400 (calculated on net remuneration from best three years). By 1971 he has obtained appointments remunerated from public funds which brings in £3,000 per annum; total remuneration with pension £3,750. An abatement figure of £350 is now applied to bring his total remuneration down to £3,400. Salaries, sessional fees, etc., have increased approximately 30% since 1967. Had the figure of £3,400 been modified to keep in step with percentage earning increases during the period 1967-71 it would now stand at approximately £4,500 and there would be no reduction in pension.

Perhaps the General Medical Services Committee will make an immediate approach to the appropriate Government department to bring maximum earning figures up to 1971 values as a first step towards the final abolition of this rule.—I am, etc.,

E. D. O. CAMPBELL

Leamington Spa

Married Women Doctors

SIR,—I would like to make a few points about the problems of married women doctors in answer to the letter of Dr. J. C. Oakley (7 August, p. 375).

It is still difficult to find a job with suitable hours to fit our particular qualifications, in the area in which we are living. If our husbands move jobs then we must move ours.

If we have children then we must find someone to look after them, and it is rare to be fortunate enough to have permanent help. Usually it is an *au pair* girl, and these only stay for about one year. This means that there is a general upheaval in the family at fairly frequent intervals.

It is often difficult to feel able to take much responsibility in a job because of our home and family commitments. Therefore we only wish to remain part-time and often seem to get used as technicians and "dogs-bodies."

With families it seems unfair to our children if we have to work through the long summer holidays. It is not always possible to take holidays to fit in with the family; it usually has to fit in with the job. There is also the occasion when the children are ill and we are more needed to deal with an emergency at home than at work.

There is a feeling of guilt. We are trying to do two jobs and may wonder if we are doing either of them really well.

There are inevitable gaps in our careers while we have our children and we may lose both our current jobs and our enthusiasm.

Possibly the least important problem, but a very real one is financial. Is it worth it? We are heavily taxed, though this may improve next year when we are taxed separately from our husbands. Also there is