largeness in body, nor no sickness, nor lack of natural functions in those things that properly belong to the procreation of children, but contrarywise, by judgement of physicians that know her estate on those things and by the opinion of women, being most acquainted with her Majesty's body in such things as properly appertain, to show probability of her aptness to have children, even at this day."³

If the evidence of this memorandum is accepted, the factors which influenced Elizabeth against marriage were probably political, psychological, and religious, not to mention personal survival, rather than any physical complaint.—I am, etc.,

M. J. PLEYDELL

Oxfordshire County Council
Health Department,
Oxford

¹ Strachey, L., *Elizabeth and Essex*, London, Chatto and Windus, 1968.

² Jenkins, E., *Elizabeth and Leicester*, London, Gollancz, 1961.

³ Read, Conyers, *Lord Burghley and Queen Elizabeth*, London, Cape, 1965.

Flatulence

SIR,—The symptom of abdominal distension (11 September, p. 595) is prominently associated with symptoms of inflammation of the urinary tract. In 40 consecutive patients in this practice, complaining either of frequency of micturition, renal angle tenderness, or both, eight complained also of abdominal distension—a "bloated feeling." This symptom diminishes *pari passu* with recovery from urinary tract inflammation in most instances.—I am, etc.,

N. B. EASTWOOD

Lowestoft

Prophylaxis of Wound Infection

SIR,—Prophylactic topical antibacterial agents are now widely used to reduce the incidence of wound sepsis. A recent study of patients in whom the alimentary or biliary tracts were opened at operation on our unit showed the efficacy of ampicillin for that purpose. There is a need, however, for alternative compounds for use in patients who show hypersensitivity to ampicillin. We wish to report our experience with the use of noxythiolin powder for this purpose.

Operative Site	Ampicillin		Noxythiolin	
	Total	Infections	Total	Infections
Biliary	9	0	10	3
Gastroduodenal	13	0	9	5
Appendix	2	1	3	1
Large and small bowel	9	2	3	1
	33	3	25	10

A trial was conducted with patients in the above category; they were randomized post-operatively to receive noxythiolin 2.5 g or ampicillin 1 g in powder form in their laparotomy wounds after closure of the peritoneal layer. The operative procedures in each group are shown in the table. Wounds were assessed on the tenth postoperative day, unless there was an indication for earlier inspection.

Thirty-three patients received ampicillin powder and three developed wound infections. *E. coli* was cultured on each occasion and two of these patients had peritonitis at operation. Noxythiolin was put in the wounds of 25 patients and 10 of them developed wound discharges. *E. coli* was cultured from one and *Ps. pyocyanea* from another, but the remainder were sterile or showed either no growth or a light growth of *Staph. albus*.

The chemical structure of noxythiolin is unlike that of other antibacterial compounds. Formaldehyde is present in aqueous solution, but its efficiency cannot be ascribed to that alone and is obscure. The high incidence of wound discharge in our series suggests that this compound may act as a chemical irritant. In our opinion it cannot be recommended for use in operation wounds in powder form.

Noxythiolin powder was kindly supplied by Geistlich Ltd and ampicillin by Beechams Ltd.

—We are, etc.,

T. A. M. STOKER
H. ELLIS

Westminster Hospital,
London S.W.1

Survival in Severe Congenital Heart Disease

SIR,—I would like to support the plea of Professor J. D. Hay (4 September, p. 579) for an expansion of the paediatric cardiology services. Now that corrective surgery is possible for an increasing number of infants with congenital heart disease, it is our duty to ensure that no infant who may benefit is denied it.

In Leeds, where expansion is taking place, there has been a brisk rise in the numbers of infants referred for urgent investigation. This has resulted in delay in investigating older children who seem less urgent. However, if these children are not referred for surgery before severe secondary effects of their heart lesions are manifest, we cannot expect optimum results from operation. More medical, nursing, and ancillary staff are needed for paediatric cardiology in regional centres throughout the country.—I am, etc.,

OLIVE SCOTT

Leeds Regional Thoracic Surgical Centre,
Killingbeck Hospital,
Leeds, Yorks

Abortion or Contraception?

SIR,—I was interested in the views of Dr. P. W. W. Gifford and colleagues (4 September, p. 584). Contraception is obviously more desirable than abortion, and the way to get contraception to all social classes, especially IV and V, is through the general practitioner. I am sure there are many willing general practitioners who have the necessary knowledge and expertise to advise and supervise patients competently on contraception. However, this work is time-consuming and so cannot, and should not, be taken on as an additional service without any financial reward, as this would lead to a lowering of the standard of general medical care.

The new service should be financed by the payment by the executive council of an item of service, paid in the same way as that for

maternity medical services. An incentive of £4 per patient per annum would encourage at least one member of each practice to take on this work, even if he felt a short training course to be necessary. If the pill, I.U.D., cap, condom, creams, foams, etc., were to be prescribed on an E.C.10, the last barrier between patient and supply would be removed. I am sure if these measures were adopted, patients would have no difficulty in getting contraceptive advice from happy and willing doctors.

Having worked out the details of the scheme with the profession, the time is then ripe to run a publicity campaign on television, radio, and in the press, with notices in the surgery waiting room and elsewhere.—I am, etc.,

DAVID S. HOLLAND

Thatcham, Berks

Pregnancy Testing

SIR,—The recent article on the "do-it-yourself" pregnancy test in *The Times* (15 September) suggests that it is surprising that women "should be prepared to pay for a test that any National Health doctor should be able to carry out free."

In some areas it is exceptional to find any pregnant woman, married or unmarried, who has not had a pregnancy test performed by the National Health Service. This test can place a heavy load on the laboratory services. For example, one hospital laboratory recently calculated that this test accounted for 16% of the entire expenditure on bacteriology.

Perhaps we should all consider whether the N.H.S. can afford this luxury as a routine beginning to a normal pregnancy, for after all, time usually tells. No one would carp at the use of this test in the abnormal case, or where the early diagnosis of pregnancy is essential on medical grounds, or for the early consideration of termination of pregnancy.—I am, etc.,

A. D. THURSZ

Cleator, Cumberland

Destruction of Case Records

SIR,—A further deplorable effect of the shortage of funds in the N.H.S. is the premature destruction of valuable medical case notes. In some hospitals it is the custom for all records of any patient who has not attended for the past 10 years to be automatically consigned by the hospital authorities to the rubbish dump. Protests from the medical staff are met by the response that there is neither storage space available nor money with which to provide it.

Ten years is a comparatively short period in most lifetimes, and there are many instances where the past history of patients is of great clinical importance. First-hand accounts of some episode of unconsciousness or unusual illness, results of special clinical investigations, and details of family history may be lost for ever. From medicolegal, historical, and research aspects the premature destruction of case records is also to be deplored. Medical research is often retrospective and it is impracticable to mark those case notes whose future preservation is speci-

ally required. Sorting and microfilming is likely to be too time-consuming to be profitable.

It is impossible for hospitals to preserve case notes for a useful period of time could not some central storage depot be instituted in each region or area, where old medical records would be available to any hospital?

It is a depressing thought that as fast as one is making careful and detailed clinical notes during one year, a "medical records destruction officer" is steadily tearing them up a few years later.—I am, etc.,

ERIC C. O. JEWESBURY

London W.1

Preclinical Salaries

SIR,—With reference to Professor G. R. Kelman's letter (28 August, p. 537) querying my statement that there is a 5% differential between the preclinical and clinical salaries, I was in error. He is correct, and I am glad he has given some concrete examples of the great disparity between clinical and preclinical salaries. I must confess that my 5% differential was quoted from memory of official B.M.A. policy, which was declared in their submission to the National Board for Prices and Incomes (1969), and which argued that medically qualified teachers should receive at least 90% of that received by their clinical colleagues.

I would point out that at the recent A.R.M. at Leicester the motion that "... all medical graduates employed in university preclinical and clinical departments should be on the same salary scale" was carried (*Supplement*, 31 July, p. 76).

It would seem from the evidence which has already been given in your correspondence columns that the differential is greater than the declared official policy of the B.M.A. This makes me more convinced than ever that a policy of no differentials between the salaries of clinical and preclinical disciplines should be adopted by the B.M.A., the Universities, and the Association of University Teachers in order to halt the deterioration in the present position and to aid recruitment in the future.—I am, etc.,

KENNETH R. HILL

Pathology Unit,
Royal Free Hospital,
London W.C.1

Hospital Staff Appointments

SIR,—It is high time that the correspondence on this subject was brought back to my original thesis, judging by your latest correspondents (11 September, p. 638) who, along with others who have equally sought to misuse its purpose in order to ventilate their grievances against appointing committees, have forgotten (or never realized) the simple point of my inaugural letter (22 May, p. 470). In effect, this stated that *having finally decided to accept an appointment*, a candidate must honour that acceptance—voluntarily, or otherwise.

While I naturally sympathize with sufferers from unpleasant experiences while seeking hospital staff appointments (and I myself have been far from immune from such ex-

periences) I submit that the correction of such malpractice must be the subject of an entirely different investigation.—I am, etc.,

J. DE SWIET

East Glamorgan General Hospital,
Glam

Sauce, Spices, and the Kidney

SIR,—I agree with your leading article (3 July, p. 6) that the number of people who take sufficient Worcestershire sauce to cause kidney damage must be small. But, when I reported the association of excess sauce and kidney stones¹ or general renal failure,² I had in mind the potential implications in people who habitually take similar spices in large amounts. The countries with very high incidence of renal tract stones include parts of India and Mexico,³ where curry and other hot spices are very popular. If these conditions can be shown to be contributing to the kidney troubles, the number of people potentially involved is very great.

I have found that most visitors from India, when offered the suggestion that curry could be a factor in their country's renal problems, react as if a national institution has been maligned. It was therefore very gratifying to note the observation by Mr. G. Holmes (24 July, p. 252) that kidney stones are very common in Fijian Indians, and scarcely ever occur in Fijians, and that the difference could be due to "curry kidney."—I am, etc.,

K. J. MURPHY

Princess Alexandra Hospital,
Woolloongabba, Brisbane,
Queensland, Australia

¹ Murphy, K. J., *Lancet*, 1967, 2, 401.

² Murphy, K. J., *Medical Journal of Australia*, 1971, 1, 1119.

³ Straffon, R. A., and Higgins, C. C., in *Urology*, ed. M. F. Campbell and J. H. Harrison, 3rd edn. W. B. Saunders Co., London, 1970, Vol. 1, p. 688.

"Clinical" and "Administrative" Pharmacists

SIR,—It is encouraging to read letters expressing apprehension at the currently held idea that the normal promotional ladder of any profession rises naturally beyond the technical field to that of administration and management.

The Health Service is concerned with the patient as an individual and the closer one works to the patient the more exacting, specialized, and demanding the work becomes. The medical profession realized this and accepted the Cogwheel system¹ as a method of self administration. At the same time it is normal to achieve professional eminence as a doctor without having of necessity to become an administrator.

Your correspondents suggest that there is a defect in the Salmon report inasmuch as a nurse can only rise up the promotional ladder by "defecting" to the administrative field. As a hospital pharmacist may I suggest that precisely the same "blind spot" appears in the Noel Hall report for the reorganization of hospital pharmacy.² At the head of the financial scale, and possessing executive power, is the regional pharmacist. Next below him is the area pharmacist controlling some 6,000 beds—probably some three or four existing groups. He is to have power of deployment of the area pharma-

ceutical forces, and his will be an administrative job.

The individual pharmacist working in a hospital may not have the authority or professional freedom which would place him on a professional level with the senior medical and nursing officers in his own hospital. Nor can he rise to any career salary level. If a "clinical" pharmacist wishes to make a promotional career he will have to desert working pharmacy for administration following the latest god of managerial efficiency.

Since the publication of these various reports there has developed some feeling that undue emphasis has been placed on the pre-eminence of managerial and administrative functions in professions which are basically concerned with scientific technicalities, and it is to be hoped that notice will be taken of these views to redirect the balance of change.—I am, etc.,

J. FOGG

Royal Alexandra Hospital,
Rhyl

¹ *Organization of Medical Work in Hospitals*. London, H.M.S.O., 1967.

² Department of Health and Social Security. Scottish Home and Health Department, Welsh Office. *Report of the Working Party on the Hospital Pharmaceutical Service*. London, H.M.S.O., 1970.

Cremation Regulations

SIR,—I should like to preface what follows by the emphatic statement that this is not intended as a criticism of Her Majesty's coroners, who, in my experience, perform a difficult task with skill and tact.

I am a referee of the Norwich Crematorium Limited, and in this capacity it is one of my duties to countersign Form F of the Application for Cremation form in cases which have been reported to the coroner and a postmortem has been held because the general practitioner or hospital doctor has been unable to sign the death certificate. I am provided with certain sections of the Application for Cremation form which are Form A (which is an application for cremation), the coroner's Certificate E, in which the coroner expresses his satisfaction that cremation may go forward, and Form F, which I am required to sign as the final authority to cremate. In Form F, it states that "I have satisfied myself that all the requirements of the Cremation Acts, 1902 and 1952, and of the Regulations made in pursuance of those Acts, have been complied with, that the cause of death has been definitely ascertained, and that there exists no reason for any further inquiry or examination."

Obviously I do not doubt the coroner's word, but I am expected to sign this form without having any knowledge of the cause of death. This has led me to correspond with the Home Office, which has been most helpful in answering my queries, and from which I gather that the changes introduced by the Cremation Regulations of 1965 were discussed with the B.M.A., the Home Office, and the Coroner's Society of England and Wales Committee. May I quote two relevant points from the letter written to me by a Home Office official?

"The purpose of Regulation 1 of these new Regulations was to remove the prohibition of Cremation, which formerly existed, in those cases in which an inquest had been opened, but not completed, although all the