general practice also. Of course, for the occasional complicated case of urinary tract infection CLED medium might be necessary, but dipslides are not intended for the full investigation of this relatively uncommon problem.

Incidentally, Dr. Rosalind Maskell's letter (28 June, p. 752) appears to misinterpret the findings of Dr. Edwards and her colleagues and also to contain a serious non sequitur. They showed that it was the CLED surface (not the MacConkey) that produced most of the false positive results and so if Dr. Maskell wishes to avoid false positives she should be using MacConkey-only rather than CLED-only dipslides.—I am, etc.,

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Antibiotic Policy

SIR,—Your leading article "Antibiotics at Risk" (14 June, p. 582) is a timely reminder to the profession of the dangers of the excessive and unnecessary use of these drugs. We believe not only that every hospital should have an antibiotic policy but that each major discipline should have one also. An account of our own antibiotic policy for surgical patients which it is hoped will help the surgeon choose the appropriate agent, is to be published shortly.¹

Not only is unnecessary systemic antibiotic prophylaxis to be deprecated, as stated in your article, but also topical prophylaxis, since penetration of the antibiotic is poor and the development of both skin sensitivity and bacterial resistance encouraged. The patient's bed clothing and the environment become polluted with antibiotic, exposing the hospital flora to the drug with the subsequent selection of resistant strains. The current vogue for using antibiotics topically in surgical wounds to prevent postoperative infection would therefore appear unwise. Two recent controlled trials have shown that the antiseptic povidone-iodine applied in aerosol form reduces wound infection both after appendicectomy² and after other abdominal operations, particularly in cases of intestinal resection and peritonitis, without inducing bacterial resistance.³—We are, etc.,

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¹ Gilmore, O. J. A., and Sanderson, P. J., *Annals of the Royal College of Surgeons of England*. In press.

² Gilmore, O. J. A., and Martin, T. D. M., *British Journal of Surgery*, 1974, 61, 281.

³ Gilmore, O. J. A., and Sanderson, P. J., *British Journal of Surgery*. In press.

Surgery of Violence

SIR,—Most of the articles in your Surgery of Violence series have been excellent. A major disappointment was the article on gunshot wounds of the trunk by Mr. H. M. Stevenson and Mr. W. Wilson (29 March, p. 728). From their references it would appear that the Vietnam war ended (medically speaking) in 1966. In fact Heaton *et al.*¹ were among the earliest authors to write about the medical care of the injured soldier in

Vietnam. As the Vietnam war continued the low transit time from injury to hospital, normally by helicopter, often less than 30 minutes, resulted in the almost unsalvageable patient reaching hospital alive. In spite of this, 98% of those arriving alive in hospital survived.^{1,2} The figures quoted by Mr. Stevenson and Mr. Wilson for abdominal injuries give a 13% death rate. No mention is made of the death rate associated with thoracic injury.

It was unfortunate that their conclusions implied that the Royal Victoria Hospital, Belfast, was in a unique position with regard to the rapid arrival of seriously injured patients. I would like to remind your readers that the military surgeon in Vietnam had the same rapid evacuation of casualties, treated the same sorts of ghastly injuries, had a lower rate of sepsis, and was able to eliminate almost completely the acute renal failure that used to follow trauma before the work of Shires,³ Moyer and Butcher,⁴ and others showed the need for adequate electrolyte fluid along with blood in the resuscitation of the severely injured. Not all the papers were published in American journals.⁵⁻⁸—I am, etc.,

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¹ Heaton, L. D., *et al.*, in *Current Problems in Surgery*. Chicago, Year Book Press, 1966.

² Chapman, R. D., *Minnesota Medicine*, 1970, 53, 93.

³ Shires, T., *Surgical Clinics of North America*, 1965, 45, 365.

⁴ Moyer, C. A., and Butcher, H. R., *Burns, Shock and Plasma Volume Regulation*. St. Louis, Mosby, 1967.

⁵ Dudley, H. A., *et al.*, *British Journal of Surgery*, 1968, 55, 332.

⁶ Knight, R. J., *Anaesthesia*, 1969, 24, 317.

⁷ Knight, R. J., *Lancet*, 1972, 11, 29.

⁸ Knight, R. J., *Resuscitation*, 1973, 2, 17.

Junior Hospital Staff Contract

SIR,—There has recently appeared in these columns not a little criticism concerning the introduction of the new junior staff contract. Indeed, one of the earliest letters voicing concern came from one of the writers of this letter (22 February, p. 458). We now feel that much of this genuine concern and apprehension is ill founded since it is based on a less than full understanding of the new contract. There are a number of points of concern that we would wish to remove.

The new contract is not based on the premise that all junior staff will be expected to work only 40 hours per week. There is no way in the interests of proper patient care that juniors can expect to do less hours than they do at present. The term "standard 40-hour week" relates only to the basis on which remuneration is made and not to the actual hours worked. It is unfortunate that the press and broadcasting media have always referred to the new contract as the "40-hour contract" since this has led to misunderstanding. From this it follows that a junior doctor will be expected to work whatever hours the consultant and he agree are necessary for maintenance of the highest standards of patient care. Thus training and service needs will not be changed in any way.

We know that some doctors do have posts which require little more than 40 hours' work per week and that they fear that their financial position will deteriorate. However, our negotiators represent all doctors and consider it of paramount importance that the

basic salary for 40 hours will never be less attractive than that they receive at present. Hopefully in years to come it will be considerably improved.

We would like to remind all junior staff that the new contract as a package whole has not been accepted until priced by the Review Body and that that is the time to assess its desirability. Until then no junior doctor should sign any new contract.

If the contract is priced realistically we believe that doctors' present concern will be allayed.—We are, etc.,

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SIR,—I should like to make known the serious disquiet felt by junior doctors in all branches of pathology concerning the effect of the new junior doctors' contract on recruitment into the specialty. This stems from the fact that there is no formal on-call commitment for many junior pathologists. The new contract is thus likely to make financial rewards in this sector of the profession compare even more unfavourably with those in the clinical sector than is already the case with the existing 80-hour contract.

There is grave danger that the introduction of the new contract will result in an increased flow of junior doctors from pathology to other specialties and that it will also strike a severe blow at recruitment, which is at best inadequate for requirements. We thus feel that the contract may severely jeopardize the future existence of a medically staffed pathology service—a disaster which would set back the standard of health care in Britain.—I am, etc.,

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Junior Members Group of the Association
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Related Ancillary Staff

SIR,—May I through your columns draw the attention of Dr. B. J. Stafford (5 July, p. 44) to the Report of the General Medical Services Committee for 1974. There he will find on p. 9, para. 83, firm proposals which the working party, of which I had the honour to be chairman, drew up with what we considered the most rigid "safeguards." These were our reply to Sir Keith Joseph's objections—that is, the difficulties with public accountability and the risk of subsequent demands for the extension of any scheme—which he raised at our meeting with him. I have personally raised at most meetings of the G.M.S.C. the question of continuing to press the Department, and we now await their paper on the subject. I can assure Dr. Stafford that I will not cease to press and press again until we arrive at a satisfactory solution.—I am, etc.,

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SIR,—Dr. B. J. Stafford's letter (5 July, p. 44), is enough to make any medical politician weep. Dr. Stafford complains that the General Medical Services Committee has not