clusive, as defined by health services management documents[4 5]). It is also likely to lead to an increase in the cost of disposing of clinical waste in hospitals. This should encourage a review of the types of waste disposed of as clinical waste to discourage inappropriate use of yellow bags—for example, in offices for disposing of confidential documents.

With the shift from hospital care to nursing home care for certain categories of patients it is no longer acceptable for clinical waste from nursing homes to be mixed with general household waste.

Problems will also arise with the disposal of pharmaceutical waste. Hospitals have always been expected to make adequate provision for the safe disposal of cytotoxic agents, volatile solvents, and unwanted or out of date medicines. Hospitals will now be subject to prosecution if infringements occur. In community pharmacies "special waste" includes all prescription only medicines.[6] Strict interpretation and the need for a detailed consignment note for the future disposal of these items mean that local "DUMP" campaigns, in which members of the public are invited to surrender their unwanted medicines, may be at risk. DUMP campaigns have been successful in collecting not only unwanted medicines but also other toxic chemicals—for example, weed killers—and every effort should be made to ensure that they continue.

Initiatives must be put in place locally to ensure compliance with the new Environmental Protection Act, though there is understandable concern over the availability of adequate incineration facilities and the likely escalation of costs for disposing of clinical waste.

PHILIP T MANNION

Chester Public Health Laboratory,
Chester City Hospital,
Chester CH2 3EG

ANN M LEWIS

Department of Pharmacy,
Countess of Chester Hospital,
Chester CH1 3ST

1 Walker A. Waste disposal: fresh looks at a rotting problem. *BMJ* 1991;**303**:1391-4. (30 November.)
2 Department of the Environment. *Waste management: the duty of care. A consultation paper and draft code of practice under the Environmental Protection Bill.* London: DoE, 1990.
3 Cheshire County Council Waste Disposal Officer. *Report to the Cheshire environmental planning and operations subcommittee.* Chester: Cheshire County Council, 1990.
4 Health and Safety Commission. *The safe disposal of clinical wastes.* London: HMSO, 1982.
5 Department of the Environment. *Clinical wastes—a technical memorandum on arisings, treatment and disposal including a code of practice.* London: HMSO, 1983. (Waste management paper No 25.)
6 Department of the Environment. *Control of pollution (special waste) regulations.* London: DoE, 1980. (No 1709.)

Randomised clinical trials in general practice

SIR,—In their comment on G Tognoni and colleagues' paper on randomised clinical trials in general practice[1] Viv Peto and Angela Coulter suggest that it is counterproductive to rely on financial incentives to persuade general practitioners to participate in research.[2] We do not entirely agree. General practitioners have little time and inclination to undertake extra work. This is especially so when such work does not give financial, intellectual, or professional satisfaction. If the experiences of Tognoni and colleagues and Peto and Coulter show us anything it is that failure lies ahead when these basic requirements are not addressed. A multicentre research project for which a general practitioner is asked to recruit a small number of patients is likely to be easily forgotten unless there is a reasonable financial incentive as such studies rarely provide sufficient intellectual or professional satisfaction.

Financial incentives alone, however, are unlikely to be enough to maintain the necessary interest of the general practitioner to ensure successful recruitment. We recently managed to enrol 300 patients through 40 general practitioners over five months for a study on seasonal allergic rhinitis. We provided a substantial financial benefit, but the timely completion of the project was also due to intense monitoring. Our clinical research associates visited general practitioners each month and telephoned them each week, generally encouraging them to keep up recruitment, resolving queries, and ensuring efficient provision of drugs, documentation, and investigators' fees.

Generally, it is difficult to get people to do something for nothing, and general practitioners are no exception. Until those organising multicentre clinical trials in general practice and elsewhere learn properly to address the needs of the participants we can expect the failures to continue to outnumber successes.

K A GUNAWARDENA
M T McMAHON

Cardiac Research Unit,
Wexham Park Hospital,
Slough, Berkshire SL2 4HL

J O'DONNELL
P ROBINSON

Chiltern International,
Stoke Poges,
Buckinghamshire SL2 4EG

1 Tognoni C, Alli C, Avanzini F, Bettelli G, Colombo F, Corso R, *et al.* Randomised clinical trials in general practice: lessons from a failure. *BMJ* 1991;**303**:969-71. (19 October.)
2 Peto V, Coulter A. Randomised clinical trials in clinical practice. *BMJ* 1991;**303**:1549-50. (14 December.)

Tenure of clinical professorships

SIR,—The idea of giving merit awards for a fixed but renewable term of five years does not seem to have aroused much opposition, and the implications of the change are interesting. On the basis of achievement the larger awards seem likely to be made to younger candidates whereas those who have not fulfilled expectations or, more commonly, have run out of steam will find this reflected in non-renewal or a lower grading. I hope that confidentiality will be scrupulously preserved so that none are humiliated and the public does not draw unjustified conclusions from publication of the awards.

But has the time not come to look at the tenure of professorial chairs in the clinical departments of universities and apply the same considerations? With the introduction in the 1930s and 1940s of full time clinical professorships in the teaching hospitals in place of Buggins's turn came an enormous improvement in the standards of teaching, research, and clinical practice. Very properly, the age at which appointments were made fell substantially so that now the early 40s is probably regarded as the ideal. But what happens when early promise is not fulfilled or the professor runs out of steam? The answer at present is nothing. Yet in some ways the result can be worse than in the 1920s and 1930s. In the days before the NHS, consultants in teaching hospitals retired at 60, though the professorial chair could be held a bit longer. Now the age is 65. Those extra years are useful but rarely very productive, and the deleterious effect of aging are no less in the 1990s than they were 60 years ago.

I suggest that all clinical professorships with charge of departments should have a fixed tenure of 15 years or until the age of 60, whichever comes first, and, at least in the same university, should only exceptionally be renewable. The title, with emeritus added, might normally remain, and the person would go back to clinical practice, personal research, or other activities. Then charge of the department, organising teaching, and fostering research would pass by normal selection procedures to a new person, presumably again in his or her early 40s, so that medicine would continue to be enriched by a well trained human brain at the peak of its performance. To bring about these changes would entail some self immolating voting by many members of the boards of faculty of medicine in the universities, but perhaps no more than when the full time posts were first introduced all those years ago.

H A DEWAR

Wylam,
Northumberland NE41 8AS

First among women

SIR,—I despair: yet another article is written about "the world's first woman doctor" being Elizabeth Blackwell—and by someone in Dublin, too.[1]

The *BMJ* itself published an article in 1989 on "James" Barry, a woman who disguised herself as a man in order to qualify and practise as a doctor.[2] Her parentage is uncertain: either her parents were the Buckleys, from Cork, or, I surmise, judging from family and other letters, she was the illegitimate child of James Barry, the Irish artist. She qualified in Edinburgh in 1812 and had an amazing career in the army.

Colours, my stage play about her, was premièred in Dublin about three years ago. I write this letter as I had hoped that fiction might succeed in establishing the truth where history had failed. I have just been commissioned to write a drama-documentary for the BBC radio series *Unsung Heroes*, and I wonder if a wider radio audience might yet help more people to know some of the facts.

I originally thought in a fairly limited feminist fashion that it was a kind of male blindness that obscured the truth—that Dr Barry achieved a position in the army (that of inspector general of hospitals, equivalent to major general) that, I think, has never been equalled since by a woman. She also, incidentally, performed the first successful caesarean section (which both mother and child survived) by an English speaking doctor. But Miles in her book *A Women's History of the World* also seems not to mention Dr Barry.[3]

Maybe women doctors today find the same difficulties: that what they do, unless they go about disguised as men, somehow does not get recorded or given credit.

JEAN BINNIE

Leeds LS16 9AD

1 Grace P. First among women. *BMJ* 1991;**303**:1582-3. (21-28 December.)
2 Hurwitz B, Richardson R. Inspector general James Barry MD: putting the woman in her place. *BMJ* 1989;**298**:299-305.
3 Miles R. *A women's history of the world.* London: Paladin, 1990.

Not Anon

SIR,—The common cormorant or shag
Lays eggs inside a paper bag . . .[1]

according not to the versatile poet Anon but to the former medical student Christopher Isherwood.[2]

RICHARD GORDON

Garrick Club,
London WC2E 9AY

1 Smith T. On lightning. *BMJ* 1991;**303**:1563. (21-28 December.)
2 Isherwood C. The common comorant. In: Grigson G, ed. *Faber book of nonsense verse.* London: Faber, 1979:292.

Correction

Chorionic villus sampling

A letter by D T Y Liu, published in the journal on 30 November (p 1402), was inadvertently published again on 4 January (p 54).