in SI units, with comparative old units and conversion factors alongside. As well as this the equivalent result in old units was included on the pathology reports alongside the SI result for several months and even now the normal range is still printed on the form. As far as the patients are concerned they have probably benefited, since for each result one consults the normal range (until it is familiar) and perhaps converts the value to old units, thus having two to compare, although this exercise rapidly becomes unnecessary.

We do not particularly like the change. But we know of no accident occurring through misinterpretation, and despite a few snags initially the system is soon used fluently—as was decimal currency.

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Penicillin-"sensitive" methicillin-resistant Staphylococcus aureus

SIR,—The last sentence in Mr D F J Brown's letter (8 November, p 344) must be disputed. He states that "methicillin-resistant strains should be reported penicillin-resistant even if apparently penicillin-sensitive when tested at 37°C." Perhaps I am naive in thinking that the purpose of the laboratory sensitivity testing is to predict the outcome of therapy in vivo. But surely to discount apparent sensitivity in vitro at 37°C makes all sensitivity testing superfluous? It is possible to make any organism appear resistant to almost any antibiotic in vitro by adjusting the conditions appropriately. Thus *Escherichia coli* is always resistant to neomycin at pH 5, pseudomonas sensitivity to gentamicin is adversely affected by divalent metal ions, and co-trimoxazole is inactivated by thymidine.

For laboratory sensitivity testing to be useful, conditions as appropriate as possible to the in vivo situation are desirable. There is certainly doubt as to the reality of methicillin resistance in vivo. It would seem wise to report such few strains as "doubtful" rather than resistant.

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Long-term postinfarction treatment with practolol

SIR,—With reference to the multicentre international study on this subject (27 September, p 735) we wish to make the following comments.

It is gratifying that our findings[1 2] of a reduction in the incidence of sudden death after acute myocardial infarction using alprenolol are confirmed by an independent study in which practolol was used. The authors of the multicentre study consider that beta-blocker therapy is especially indicated in patients with anterior wall infarcts.

In order to be able to apply the results and conclusions drawn from a study to other groups of patients the original patients must be representative of the general population of infarct patients. It is impossible to assess the representativeness of the patients in the multicentre study without knowing the numbers of and reasons for the exclusions. There might have been a selection of patients in this study, as reflected by the low total mortality.

The main end points used in the study were death and reinfarction. Neither of these terms is clearly defined by the authors. We are, however, uncertain where data on the patients who died more than 24 hours after the onset of symptoms and/or the last dose of practolol are presented. A large number of patients dropped out of the study and 39% of the patients who died did so after withdrawal.

If sudden death is accepted as the main end point table VI shows that it is more important to discriminate according to blood-pressure levels than site of infarct. The reduction in the incidence of sudden death was the same among patients with anterior wall infarcts and those with posterior wall infarcts. It is probable that patients with large infarcts, with a complicated clinical course and a poor prognosis, have lower blood pressures than others on discharge from hospital. The retrospective demonstration of the importance of the diastolic blood pressure seems questionable since the mortality in the group given placebo was the same in patients with high and low pressure. The meaning of results from a discriminant analysis such as this must be prospectively validated. The material presented, therefore, does not permit the conclusion that beta-blockade is especially favourable in cases of specific infarct location.

A reduction in sudden mortality has so far been shown for two beta-blockers only, practolol and alprenolol. Other beta-blockers should be used for this indication only when clinical trials have shown that they possess the same property.

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1 Wilhelmsson, C E, *et al*, *Lancet*, 1974, 2, 1157.
2 Vedin, A, Wilhelmsson, C, and Werkö, L, *Acta Medica Scandinavica*, 1975, suppl 575, p 1.

Rheumatic heart disease in South Africa

SIR,—The study of rheumatic heart disease (RHD) in Soweto (23 August, p 474) is an epidemiological classic. Dr M J McLaren and his colleagues have exposed the dimensions of a rampant but preventable illness. Small wonder that they should have added this monumental task to their already burdensome duties. As Professor Barlow's guest at both Johannesburg General and Baragwanath hospitals I was struck by the unbelievable numbers of quite young Black patients with every conceivable kind and complication of advanced rheumatic heart lesion.

In other Western countries we still see RHD mainly in the poor, but less and less of it and usually not in an advanced stage until at least the third decade. Because the decline in RHD began even before we had effective antimicrobials we can relate it in part to improved conditions for the urban poor, including better medical attention. Primarily, however, high prevalence of streptococcal infection and its consequences remain among the many scourges of poverty, afflictions that can be literally rooted out by socioeconomic amelioration. At the same time the physician's duty is clear: to press for massive intervention with public health measures including community education, constant case finding, and preventive treatment.

Dr McLaren and his colleagues propose a comprehensive preventive campaign against RHD while improving the lot of the Black community. For this these outstanding humanitarian scientists need no further documentation. Yet I suspect that they may need powerful support from their colleagues abroad because, as I have personally witnessed, the situation is appalling despite the efforts of the already overworked Johannesburg physicians.

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Merrison Report and overseas doctors

SIR,—Although the Merrison Report[1] was published some months ago there has been singularly little informed discussion in public about it and its recommendations. Some interested organisations have readily accepted it and the British Medical Association wants the implementation of its recommendations. Controversial measures have already been taken on its recommendation which may have far-reaching consequences for the NHS.

I would like to draw the attention of your readers to paragraphs 181-5 in part C of the report. These deal primarily with the assessment of overseas doctors—a euphemism in this report for coloured doctors from the New Commonwealth and Middle Eastern countries—and the term is often used pejoratively. The methods of assessment and conclusions are open to serious objection on the following grounds.

(1) There was not a single member from the minority ethnic groups on the committee. (2) None of the medical members of the committee had any reasonable and personal knowledge of the cultures of the overseas doctors or personal experience of working with them in Britain or abroad. (3) Out of 140 persons and organisations listed in appendix A from whom evidence was received, there was not one single immigrant doctor or organisation representing solely overseas doctors. (4) The objective and subjective evidence described in the report would not satisfy any careful and impartial investigator. This evidence was received from chosen sectors of society—that is, the royal colleges, whose membership is well known for preconceived notions and rigid attitudes against immigrants generally—but completely ignored the consumers, the patients whom both British and overseas doctors treat. In other words, complaints were received from all other interested sources except from patients or their organisations. (5) The deputising services and other agencies which have considerable experience of working with overseas doctors will not wholly agree with the "inescapable conclusions" reached by the committee. (6) The number of complaints to family practitioner committees do not show any unduly large proportion against overseas