were selected for this study. Significant improvements in the responses to suprascapular nerve block have been found, and it is now important to analyse in a more precise way exactly which patients benefit; these studies are now being undertaken.

Dr Burn questions the choice of methylprednisolone in addition to local anaesthetic. This was purely an empirical decision introduced to us by our anaesthetist colleagues. It had been their practice to use this combination for temporary nerve block both for the intercostal nerve and for the suprascapular nerve, and we had found this successful in an uncontrolled pilot study. As Dr Burn points out, the effect of steroid in epidural injections is assumed to be anti-inflammatory, but this is by no means proved. It may well be that steroids have a quite separate and important effect on membrane stabilisation and perhaps a secondary reduction in pain. This is obviously an important question to address and we are currently investigating with a controlled trial. We regard the nerve block as a screening procedure that, if successful, would logically lead to a more definitive approach and are ourselves investigating alternative methods of producing long term neuroloysis.

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Risks of donor insemination

SIR,—The leading article by Dr Christopher Barratt and Professor Ian Cooke on screening of sperm donors[1] is one of several in recent years exphasising the importance of adopting suitable precautions to prevent the transmission of an increasing number of sexually transmitted diseases to women receiving donated sperm. In the Oxford artificial insemination by donor programme we are particularly interested in screening for chlamydial infection.

Fifteen consecutive new prospective donors (university students) were initially screened serologically using fluorescence antibody technique tests and those with positive results underwent enzyme linked immunosorbent assay (ELISA) testing on urethral swabs. The prospective donors were questioned about the acceptability of these procedures and the frequency with which they would be prepared to have them performed. Results of 14 of the fifteen fluorescence antibody technique tests were reported as titres >1/64, which suggested active infection. Not one of these 14 donors tested positive on urethral swabs. All the donors thought that screening for sexually transmitted diseases was important. All 14 who had urethral swabs thought that repeat swabs at six monthly intervals were acceptable, and 12 were prepared to have swabs at each change of sexual partner. Only one, however, was willing to have swabs taken at every donation.

The incidence of chlamydia in students is 2%[2] and in donors 6·3%.[3] There is only one documented case of chlamydial transmission by artificial insemination by donor,[4] and even in this report it is possible that chlamydial infection predated the insemination. This is a very low recorded rate of transmission considering the incidence of the organism in the donor pool and number of artificial insemination cycles performed world wide.

Our results confirm that serology is too nonspecific to be used as a screening test for chlamydia. A positive result gives no information about when exposure took place or at which site the infection occurred. Urethral swabs are both the most reliable and the recommended method for detecting chlamydia. To exclude the possibility of transmission swabs would have to be taken at each donation, although this is clearly unacceptable to prospective sperm donors. In view of the small risk of transmission of chlamydia to patients receiving artificial insemination we think that urethral swabs taken at six monthly intervals or at change of sexual partner should provide adequate protection to patients while at the same time being acceptable to donors.

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1 Barratt CLR, Cooke ID. Risks of donor insemination. *Br Med J* 1989;**299**:1178-9. (11 November.)
2 Podgore JK, Holmes KK, Alexander ER. Asymptomatic infections due to Chlamydia trachomatis in male US military personnel. *J Infect Dis* 1982;**146**:828.
3 Tjiam KH, Van Heijst BYM, Polak-Vogelzang AA, *et al.* Sexually communicable micro-organisms in human semen samples to be used for artificial insemination by donor. *Genitourin Med* 1987;**63**:116-8.
4 Nagel TC, Tagatz GE, Campbell BF. Transmission of Chlamydia trachomatis by artificial insemination. *Fertil Steril* 1986;**46**: 959-60.

General practitioner contract

SIR,—I reject the motion of censure that Scrutator has proposed on those of us in the General Medical Services Committee who voted to seek another counsel's opinion on the legality of an imposed general practitioner contract.[1]

Scrutator may think that "spending time, money, and credibility on a doubtful legal cause is . . . poor politics,"[1] but unfortunately it is the only possible politics.

Everyone would like to believe that Lord Denning's opinion that the secretary of state was wrong in law to impose a new contract is correct, and most of those we represent will continue to insist that it is correct until the case has been defeated in open court.

My local medical committee argued the case for "testing the legality of this arrangement in every court which might have jurisdiction" at the special conference of local medical committees in June 1989.[2] The motion was carried and I have just written to the GMSC to say that Ayrshire and Arran Local Medical Committee wishes the matter to be taken to judicial review without further delay.

Many general practitioners have loyally contributed to the GMSC defence fund over the years, and the grass roots are now giving a clear message that they want some of this money used for a full scale legal battle with maximum publicity. The disadvantages of such action do not seem to outweigh the necessity to try to defeat Kenneth Clarke.

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1 Scrutator. Lord Hill remembered. *Br Med J* 1989;**299**:1304. (25 November.)
2 Beecham L. Committee calls special conference on contract. *Br Med J* 1989;**299**:1342-4. (25 November.)
3 Beecham L. Contract rejected; ballot called; more talks wanted. *Br Med J* 1989;**299**:57-60. (1 July.)

*Scrutator writes: "My comments were in no way a motion of censure, just a personal view that the GMSC's decision would lead up a legal cul de sac, as the further legal opinion announced on 7 December has confirmed (p 1534). I derive no pleasure from the outcome as I believe that though the Secretary of State for Health has acted within the law in imposing a 'new contract' his decision will prove counterproductive by antagonising general practitioners and evaporating the professional good will from which the NHS has so greatly benefited."—ED, *BMJ*.

Senior house officers and their training

SIR,—I read with interest the paper by Dr Janet Grant and colleagues regarding senior house officers.[1] As the junior representative of the South East Thames regional study leave appeals committee I was not surprised at the perception of service and training among junior hospital staff in the region. Our committee considers appeals from doctors who have encountered difficulty in obtaining study leave within the South East Thames region. These cases are dealt with according to the study leave regulations laid down in the document *Terms and Conditions of Service for Hospital Medical and Dental Staff*.[2]

Recently, however, it has come to my attention that certain hospitals within the region are determining study leave solely on financial grounds. Consequently some junior doctors are not obtaining study leave to which they are entitled. Concern has been expressed by the South East Thames Regional Hospital Junior Staff Committee, and discussions have taken place between certain hospitals and the industrial relations officer of the BMA. Our committee receives appeals only from doctors who are aware of the committee's existence. I feel sure that many juniors have study leave denied and yet do not appeal. thus diminishing even further the meagre training that many posts offer. Of even more concern is the advent of the white paper and its implications for training. Will those hospitals that opt out be willing to undertake the training commitment that many hospitals at present choose to ignore?

Until study leave becomes a statutory part of junior posts either as day release (which seems both impractical and unacceptable in manpower and training terms) or as periods specifically set aside during the tenure of a post these inequities will continue to prevail and junior doctors will continue to serve their employing authorities rather than being trained by them.

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1 Grant J, Marsden P, King RC. Senior house officers and their training. II. Perceptions of service and training. *Br Med J* 1989;**299**:1265-8. (18 November.)
2 Department of Health and Social Security. *Terms and conditions of service for hospital medical and dental staff*. Heywood, Lancashire: DHSS, 1988. ((MD) 3/87.)

Corrections

Death after flumazenil

An author's error occurred in the letter by Dr A G Lim (30 September, p 858). The patient was given an intravenous bolus of 3·5 ml flumazenil (100 μg/ml), not 100 g/ml as published.

Cervical intraepithelial neoplasia in general practice

A printer's error occurred in this letter by Dr Kambiz Boomla and others (25 November, p 1340). In the table the final heading should have read "Grade II or above" and not "Grade IV or above" as published.

Acute renal failure after infusion of gelatin

An authors' error occurred in this letter by Drs P J T Drew and S F Hussain (2 December, p 1399). The letter should have stated that potentially nephrotoxic fluorinated agents were not used; in fact isoflurane was given together with nitrous oxide and oxygen.