is not simply one of courtesy, but of practical importance.—We are, etc.,

JOHN D. W. WHITNEY
B. R. COLLIER
B. JONES
P. B. DANDO

Lichfield, Staffs

Prolonged Effect of Antihypertensive Agents

SIR,—In their article on the antihypertensive effect of prazosin (11 May, 298), Dr. G. S. Stokes and Dr. M. A. Weber mention that in their experience with this drug the blood pressure, once controlled, may remain within normal limits for up to a month after stopping treatment. We have recently observed the same phenomenon after discontinuing therapy with indoramin in hypertensive patients,¹ when normotension may continue for considerably longer than four weeks. Indoramin also has adrenoceptor blocking activity.^{2,3} Since prolonged normotension is seen after discontinuing other antihypertensive agents however,⁴⁻⁶ this effect may well be due to a common mechanism such as "barostat" resetting⁵ rather than a direct action of the drugs themselves.

This phenomenon complicates the design of clinical trials, as Drs. Stokes and Weber point out. It also suggests⁴ that morbidity due to antihypertensive agents could frequently be avoided by stopping or reducing the dose of these drugs after long periods of satisfactory blood pressure control.—We are, etc.,

C. DE B. WHITE
R. B. ROYDS
PAUL TURNER

Department of Clinical Pharmacology,
St. Bartholomew's Hospital Medical College,
London E.C.1

- 1 White, C. de B., Royds, R. B., and Turner, P. *Postgraduate Medical Journal*, In press.
- 2 Alps, B. J., et al., *British Journal of Pharmacology*, 1972, 44, 52.
- 3 Royds, R. B., Coltart, D. J. and Lockhart, J. D. F., *Clinical Pharmacology and Therapeutics*, 1972, 13, 380.
- 4 Page, I. H. and Dustan, H. P., *Circulation*, 1962, 25, 433.
- 5 Thurm, R. H. and Smith, W. M., *Journal of the American Medical Association*, 1967, 201, 301.
- 6 Persson, I. and Ulrich, J., *European Journal of Clinical Pharmacology*, 1973, 6, 217.

Contamination of Blood Cultures from a Commercial β -Lactamase Preparations

SIR,—We wish to report an unusual source of contamination in blood cultures which led to clinical confusion in this hospital and may well have confused other microbiologists.

Between 15 March and 19 April 1974 blood cultures from eight patients yielded a variety of oxidase-positive Gram-variable and Gram-negative bacilli with different antibiotic sensitivities. The organisms from two pairs of patients were apparently identical. In every case the bacteria were recovered only after several days' incubation and there appeared to be no possible epidemiological connexion between the two pairs of patients with similar organisms.

It was then realized that all eight patients were receiving penicillin or cephalosporin therapy at the time their blood was taken for culture and that "penicillinase" had therefore been added to the culture medium in

each case. We had recently begun using a new "penicillinase" preparation manufactured by Whatman Biochemicals, a broad-spectrum β -lactamase with both penicillinase and cephalosporinase activity obtained from *Bacillus cereus* 569/H9. One batch of this product (10B) had been used for all the blood cultures and we still had three unused vials. We tested these for sterility by adding five drops of the β -lactamase to our usual blood culture medium and subculturing after one week's incubation at 37°C. From five of the 12 cultures set up bacteria were recovered and in three cases they were identical with those isolated previously from blood cultures. We finally identified the organisms, with some difficulty, as *Bacillus* spp. and it became clear that the Whatman β -lactamase was the source of the contamination.

The β -lactamase preparation is tested for sterility by the manufacturers by incubation in nutrient broth for 48 hours at 37°C. When β -lactamase is added to blood culture media it will frequently be subjected to incubation for considerably longer than 48 hours. Whatman Biochemicals have now assured us: firstly, that they were unaware that their β -lactamase might be used in this way and had considered that most users would incubate the preparation for only 24 hours, as for instance in antibiotic assay work; secondly, that in future their sterility tests on the product will be much more stringent; and thirdly, as a result of tests which they have carried out, that only batch 10B had been contaminated.

We have had no further trouble with contamination from this source, but have taken the precaution of filtering the β -lactamase through a 0.22- μ m Millipore filter.—We are, etc.,

R. LYNN
SUSANNAH EYKYN

Microbiology Department,
St. Thomas's Hospital,
London S.E.1

Minors and Contraception

SIR,—Dr. J. D. Beale (8 June, p. 563) treats the whole subject of family planning within the Health Service as though Mrs. Barbara Castle had reversed or changed the policy of the previous Government. This is not so. Neither can it be said that Health Service family planning was decided upon without a great deal of discussion and debate in both Houses. Furthermore, it must be pointed out that completely free services in respect of family planning were being provided in many large cities and boroughs in Great Britain long before Mrs. Castle's announcement. These included Birmingham, Sheffield, Glasgow, and the London Boroughs of Camden and Islington, to name but a few. These local authorities had made it clear to both the Conservative and Labour Governments that they considered it a retrograde step to start levying charges where there were none before, because they knew that any sort of charge would deter the very people who needed their services most. Mrs. Castle therefore wisely extended what the most progressive and far-sighted of the local health authorities had already done to the rest of the country.

The Family Planning Association's wholehearted support for the decision to impose no age limit on supplies of con-

traceptives, following appropriate consultations, is based in part on the knowledge that 95% of the young people who come to our clinics are already sexually active.

Allegations that the availability of contraceptives increases promiscuity are unsubstantiated. In fact, such evidence as does exist points the other way. A report produced in 1971 on a survey of 3,000 unwanted pregnancies¹ showed that the more fleeting the relationship the less likely were those involved to use contraceptives. Of those in stable relationships, 25% used contraception; 16% in temporary relationships used it, and only 4% of those involved in casual sexual relationships did so.—I am, etc.,

MICHAEL SMITH
Chief Medical Officer,
Family Planning Association

London W.1

- 1 Lambert, J., *British Medical Journal*, 1971, 4, 156.

Tests for Immigrant Doctors

SIR,—Dr. M. Sim's letter (15 June, p. 614) on tests for immigrant doctors, like his earlier article on the E.C.F.M.G. (*Supplement*, 8 December 1973, p. 65) has ignored a number of matters which the General Medical Council, in devising its proposed mode of testing, has felt bound to take into account.

The G.M.C. concluded that the E.C.F.M.G. examination was unsuitable for British needs. It tests a doctor's power of factual recall and to some extent his comprehension of the spoken word. It does not test his ability to speak English. Further, the examination uses only multiple choice questions and thus does not test the doctor's ability to write English.

The council is able to form some idea of a doctor's basic knowledge from the information which it has about the institution where he qualified. It was felt, however, more than 18 months ago that it would be desirable to supplement this by testing the doctor's ability to speak, write, and understand the sort of English used in the course of medical practice in Britain. Early in 1973 the Council invited the three non-university examining bodies to see whether arrangements could be made to test and assess these matters. These bodies, with the aid of linguistic experts, have made considerable progress in devising these tests. The tests will also include components designed to test the doctor's professional knowledge. The Department of Health appears favourably disposed to proposals to supplement the tests by an improved scheme of attachment to consultants whereby the ability of the doctor to practise acceptably in British hospitals will also be assessed. Plans are advanced to introduce these tests and to make the necessary improvements in the clinical attachment scheme during 1975.

Until the law is changed these tests can be applied only to doctors applying for temporary registration. The G.M.C. has indicated to the Morrison Committee that the G.M.C. would favour an end to the present system of reciprocity but, even if the Morrison Committee and the Government endorse these recommendations, legislation will be needed to accomplish the change. The formal tests and assessments

now being planned in relation to temporary registration will give valuable experience should it later be judged desirable to apply these tests to a wider range of doctors.—I am, etc.,

M. R. DRAPER
Registrar, General
Medical Council

London W.1

Married Women Consultants

SIR,—In all the letters and discussion about 10-session contracts for consultants and whether or not private practice should be allowed I have seen no mention of married women consultants who, like myself, elect to do maximum part-time work not to do private practice but so that they can have a modest amount of time to cope with the problems involved in trying to run a house as well. I know that the numbers are quite small at present, but if more consultant posts are going to be occupied by women doctors I think some degree of flexibility is essential.—I am, etc.,

CYNTHIA M. ILLINGWORTH

Accident and Emergency Department,
Children's Hospital
Sheffield

Finance and the Health Service

SIR,—The last paragraph of the letter from Mr. A. N. Harris (15 June, p. 615) should be printed in letters of gold and displayed in all medical schools and notably in the headquarters of the B.M.A.

How long has our profession been waiting for such a clarion call from its leaders? In the end it has to be sounded by a medical student. This is a superb letter and worthy to be reprinted and circulated to all doctors. It shames me, as a Fellow of the B.M.A. with a membership of over 55 years, to find such a great and once noble institution striving with at least 75% of its energies to extract more money from a penurious country (not Government) for distribution to a profession which, in my lifetime of 85 years, has never been so prosperous.

The points raised in Mr. Harris's letter are all vital to a profession which cares, and it shows a return of thought towards those ideas which make medicine a vocation and not just a means of livelihood.—I am, etc.,

CYRIL F. MAYNE

Rye, Sussex

Overtime Pay in Denmark

SIR,—I left Britain in April of this year to work in Denmark and have followed the discussions about working hours and pay of junior hospital doctors with some interest. I should like to comment on one or two features of the Danish National Health Service relevant to the discussion.

The basic working week for junior hospital doctors is 40 hours, and any extra time worked counts as overtime. I use the word "overtime" as the accepted English translation of a Danish word which literally means "overwork." Perhaps this is fortuitous rather than by design. The exactness of the definition of the working week is reflected in the method of payment for the overtime

worked, for the Danes find a set rate per hour fairly easy to calculate.

The Danish junior hospital doctors, and perhaps I should say that they exceed in numbers the posts available, consider the extra duty payments quite an important part of their salary. So much so that those doctors who are unable to perform extra duties because their post does not demand it—for example, in histopathology—receive a substantial supplementary payment each month.

As far as I am aware no such suggestions have ever been made in the British National Health Service for the obvious reason that the basic working week is so long. One could, of course, argue that the doctor who chooses of his own free will to work in a post where extra duties are not performed is indeed a lucky man and needs no extra benefits; he has the solace of a normal family life and plenty of time to study. But perhaps most important of all he also has the opportunity to earn more, so that he can sustain a normal family life, by working for the local deputizing service and general practitioners. Perhaps I should not disclose that he still does this in Denmark.—I am, etc.,

BRIAN NAYLOR

Pathology Department,
Finsen Institute,
Copenhagen

Payment of Members of District Management Teams

SIR,—The consultant member of a district management team (22 June, p. 674) who has rejected the salary offered for this work does the whole Health Service a disservice by his altruistic gesture. One of the main reasons for our present discontent and the near breakdown position of the service is the persistent failure to reward adequately in all disciplines long and devoted unselfish service. I am sure as a general practitioner member of a D.M.T. I can be of use only because of my many years long service on voluntary committees such as local medical committee, executive council, hospital management committee, etc. Indeed I believe I was nominated to the D.M.T. to represent my colleagues because they recognized the value of such hard-won experience. I have given of my spare time freely and willingly to all those committees at some personal inconvenience and financial loss for the benefit, I hope, of patients and colleagues alike for 25 years. If the N.H.S. wants the benefit of my expertise in a managerial and advisory capacity then it is only right that it should at least attempt to pay me. I am confident enough to think that my knowledge if properly applied might easily prevent some disastrous financial or administrative error and even in "work study" terms justify the expenditure of £700 per annum. It should be remembered that my consultant colleague may be covered within his department for time spent on the D.M.T., whereas my participation is at the expense of my spare time or the working time I would otherwise devote to my patients in our partnership.

I agree wholeheartedly that the Department of Health and Social Security should make additional funds available for such expenditure, but I do not think

that by offering to do such work voluntarily we will make anyone see the light or improve the service.—I am, etc.,

G.P. D.M.T. MEMBER

B.M.A.'s Evidence to Review Body

SIR,—In the summary of the B.M.A.'s evidence to the Review Body concerning the discrepancy between general practitioner and consultant remuneration (*Supplement*, 22 June, p. 119), one finds the following statement: "No hospital salary structure, the B.M.A. states, can be expected wholly to compensate for the earlier higher earnings of a young general practitioner."

This is an astonishing revelation of the thoughts of our negotiators and it will surely confirm the opinion, already held by many consultants, that this committee has been very effectively brain-washed.

Why on earth should a consultant, after many years of additional study and searching higher examinations, expect to receive less in total remuneration than a general practitioner? We have been told that hospital practice provides "job satisfaction." Are we to assume that general practice is devoid of this? As a consultant radiologist I find that the amount of satisfaction that I derive from my job is directly related to the effort that I put into the job, constantly to maintain and increase my diagnostic accuracy in the interest of the patient. Are we now to be told that the harder we work, the less we deserve to be paid?—I am, etc.,

GEORGE ANSELL

Liverpool

** We regret that in summarizing this part of the report a misleading impression should have been given. The paragraph preceding the one from which this sentence was abstracted provides the context to the statement Dr. Ansell criticizes. The relevant passage in the full evidence reads as follows:

"For the doctor and dentist, as for other professions, the time of heaviest demand on resources—marriage, house purchase, children and their education—is normally between age 25 and 45. And yet, the younger men and women who wish to take up a consultant career are in this respect at a grave disadvantage. With the average age of consultant appointment still about 37, the achievement of the top of the basic salary scale may well be postponed until after 45. . . . In other words, the present arrangement provides for the average consultant a peak of earnings only after his years of maximum need, and during his years of maximum taxation; moreover, throughout their careers consultants are at a relative disadvantage in this latter respect, being assessed wholly or partly under Schedule E.

"In the light of these considerations no salary structure can be expected to compensate wholly for the earlier higher earnings which a young full-time general practitioner can expect. Nevertheless, the position would be improved with the greatest effect by a significant increase in the basic consultant scale, accompanied by corresponding increases in the salaries of the other career grades."—ED., *B.M.J.*