gastric contents allowed bacterial growth and that erosion of the gastric mucosa was of bacterial origin. Examples of these cases were reported in 1972.[6] It would appear that in some cases treatment with alkali is contraindicated. The methods used to stop massive bleeding have been irrigation of the stomach with iced saline, partial gastrectomy, and cannulation of the superior mesenteric artery and infusion of pitressin.[8 9] None of these has been totally successful.

There is a further aspect to this problem. When samples are obtained during endobronchial suction culture revealed that the organisms in the respiratory tract were identical with those in the stomach. It appeared therefore that the stomach provided a reservoir of organisms and possibly prolonged the respiratory infection. Following these investigations, patients with a high intragastric pH with proved bacterial contamination were treated with antibiotics given down the nasogastric tube. In two of these patients bleeding stopped. In Britain we have had one patient[7] in whom a high pH, organisms, and free blood or accumulation of red cells were found in the intragastric contents. This patient was treated with dilute hydrochloric acid and no stress ulceration occurred even though artificial ventilation of the lungs proceeded for more than seven weeks.

Further investigations into this highly lethal condition are required. Antacids, however, as a "prophylactic approach" are not to be recommended without prior and repeated measurement of the pH and acid content of the gastric secretions.

DAVID BROOKS

London W1

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Wessex Adjuvant Breast Study

SIR,—At a recent meeting organised by the Breast Trials Co-ordinating Committee a number of adjuvant chemotherapy studies were criticised on the grounds that they were unlikely to achieve an adequate patient recruitment.

The Wessex Adjuvant Breast Study was set up because of the desire of a group of clinicians to offer chemotherapy to node-positive breast cancer patients. We accepted that it was unethical to offer this form of therapy outside the context of a study and we therefore agreed to establish our own, no satisfactory alternative being available.

Since our study opened a number of surgeons have agreed to participate, but despite this recruitment remains low and it will be some years before we reach adequate patient numbers. Newer and larger trials that meet all our requirements for an adjuvant study are now available and we feel therefore that it is unethical for us to continue our protocol. Our reason for writing to you with this information is that we hope that the closure of our study may encourage others critically to examine the practicability of their own programme, since there are obviously many British groups of comparable size to ours which are likely to experience very similar recruitment problems.

JAMES FRASER
R B BUCHANAN

Royal South Hants Hospital, Southampton

F I TOVEY
A B RICHARDS
R J HEALD

Basingstoke District Hospital, Basingstoke, Hants

N COWLEY
R C SHEPHERD

Poole General Hospital, Poole, Dorset

A B OLIVIERA

Royal IOW County Hospital, Ryde, IOW

Surgery after irradiation

SIR,—I should be grateful if any reader could give me some help with the management of a group of patients which have become a surgical nightmare. I refer to those with primary malignant disease of the tongue, floor of mouth, or laryngopharyngeal region who have failed to respond to radiotherapy. These hopeful and brave patients are subjected to surgery which is frequently followed by delayed healing and fistula formation and may require a series of reconstructive procedures carried out under the most difficult surgical conditions. In some cases inoperable recurrences appear by the time repair is complete. I have tried most of the techniques described in the literature (and a few that are not), but the high mortality and morbidity make me wonder whether surgery has any place in management. It certainly speeds up the demise of some of the patients, but that is not what surgery is for.

I should like to know, for example, whether it is better to carry out the resection and reconstruction very soon after the completion of irradiation, or will this mean unnecessary surgery on some who have been cured by radiotherapy?

B S CRAWFORD

Plastic and Jaw Department, Royal Hospital Annexe, Fulwood, Sheffield

Appointments in Iran

SIR,—Dr E Grey-Turner, Secretary of the British Medical Association, writes (11 February, p 371) referring to disturbing reports which he has received concerning the conditions of service of some British doctors working in Iran.

The undersigned, all doctors working in this hospital, which is staffed by British-trained consultants, would like to make it clear that so far as we know these reports do not emanate from doctors now working in this hospital.

R BALLARD
M A SEDDIQ
F L A VERNON
H HEGGARTY
ROY K ROWLEY
NICHOLAS WOODHOUSE
G P MCMULLIN
R FRANCIS

Notre Dame de Fatima Hospital, Tehran, Iran

Doctors to tradesmen

SIR,—It has become part of certain consultants' symptomatology to behave in a self-righteous manner whenever they discuss the role of the junior hospital doctor. Repeatedly we hear how they, as junior doctors, were forced to work Olympic hours on slave-like wages in sometimes primitive and inhumane conditions as if these criteria were part and parcel of the making of a good doctor with subsequent better patient care. They not only see their counterparts today as living a life style which makes them spoiled degenerates but also see their tame efforts at reform as outright insubordination and militant trade unionism.

In his recent letter entitled "Doctors to tradesmen" (11 March, p 633) Dr Eoin O'Brien subscribes to the idea that patient care is in jeopardy because of the shorter hours now worked by junior hospital doctors. Dr O'Brien equates continuity of care with quality of patient care, but is this always the case? Is it one doctor working 24 hours, seven days a week or is continuity provided under the present system whereby a junior hospital doctor works a basic 140 hours a fortnight (often being required to work longer)? Does he imply that leisure and sleeping hours be exchanged for a "thriving hospital mess" life? Dr O'Brien may have spent "many . . . entertaining hours" in this establishment. However, the present more mature doctors would prefer to spend their hours with their family and loved ones.

We hold that quality of care is maintained under the present system because an equally well trained alert doctor is assuming duties from his tired, overworked colleague who, contrary to Dr O'Brien's belief, always ensures that the former is fully briefed on all sick patients. Not to do this would constitute gross irresponsibility. ("Doctors and administrators may argue against the concept of continuity of care, but will the patient? Since the substitution of cross-cover for continuity of care, the patient, whether acutely or chronically ill, may be cared for by his own doctors during normal working hours, but when 5 o'clock, the weekend, or a bank-holiday comes God knows who will be called to him in his greatest need.")

It is unfortunate that the issue of adequate remuneration is central to the quality of patient care. Overworked, underpaid doctors do not provide a good service in a society imbued with social pressures and high standards of living. Times change and we change with them.

PHIL HARRINGTON
and 23 other junior hospital doctors

Jervis Street Hospital, Dublin

Reform of the GMC

SIR,—I would like to add my voice in support of what you have stated in your recent leading article "Most of Merrison" (4 March, p 532). The Overseas Doctors' Association believes that the Medical Bill now going through Parliament with the amendments concerning overseas doctors will be of great benefit to the medical profession and maintenance of high standards of medical practice. I wish the Medical Bill a speedy and successful passage through the House of Commons and plead with members of Parliament to give it their unanimous blessing.

Some doctors appear to have misunderstood my comments (17 December, p 1600) on

specialist registration and the EEC. I wish to make it understood that the Overseas Doctors' Association is seeking the right of freedom of movement in the European Economic Community for *all* overseas doctors who are British nationals and fully registered to practise in this country and not specialists only.

S A A GILANI
General Secretary,
Overseas Doctors' Association in the UK
Manchester

Distinction awards

SIR,—Dr C I Haines (18 March, p 721) has missed the point which was made by Drs D B Shaw and G H Hall (4 March, p 582). Some system must exist to ensure that worthwhile extracurricular work is rewarded. Research and development certainly should be, by analogy, if the rewards of private practice attract men of intelligence and energy. It is irrelevant to bring the question of full or part-time commitment into this issue. My colleagues Drs Hall and Shaw are both, incidentally, part-timers.

W B WRIGHT
Royal Devon and Exeter Hospital
(Heavitree),
Exeter

SIR,—We knew we should risk leg-pulling, but our study of the composition of the advisory committees (18 February, p 456) has provoked letters from two ex-chairmen, Lord Platt (4 March, p 582) and Mr B H Price (11 March, p 652), whose tone (one "standing up to be counted") suggests that we touched a raw nerve. Mr Price and the West Midlands do deserve credit for the local effort he describes to be fair, but we doubt if, even with prior homework, "almost an entire day" is enough to evaluate the order of merit in which to rank several hundred consultants from 20 different specialties, especially when the committees are slanted in their own composition. We have shown that the top seven specialties best at getting awards are, in fact, over-represented on the advisory committees (2879 consultants with 187 seats), three- or fourfold compared with the bottom seven (4544 consultants with 88 seats). It seems that Lord Platt and Mr Price see nothing at all wrong with this ("the most democratic form of award-selection I have ever known"—Mr Price) and, for all we know, they may be right to focus more on our conspicuous personality defects. The impartial reader must decide.

We are glad at Lord Platt's frank admission that secrecy was meant to minimise quarrelling—a good reason but outweighed by far too many others. The ex-chairman's good-humoured digs about underlings and chips and shoulders do nothing to efface our sense of older colleagues who have done precisely what Lord Platt and Mr Price suggest—namely, working out their professional lives, developing their subject with devotion, and attaining considerable reputations here and abroad—yet they approach retirement with nothing.

In pressing his case for the special treatment of those specialties he sincerely admires most Lord Platt asks for butter on both sides of the bread. If intense competition for careers in some fields does produce such an oversupply of distinguished consultants it cannot also be these same specialties which need the extra cash to keep enough good recruits in this country. It is a shabby argument either way: neither we nor Lord Platt stayed here for the money.

Finally, we were wryly entertained by Lord Platt's suggestion that we take a lead from Cassius ("The fault, dear Brutus, lies not in our stars but in ourselves . . ."), the instigator of a conspiracy to put a knife in a friend's back. The "fault" in Brutus was to have scruples. Et tu, Platt?

S BOURNE
P BRUGGEN
Tavistock Clinic,
London NW3

General practitioners' contract

SIR,—With all the discussion at present going on over a new general practitioners' contract may I please air my own views?

There is nothing whatever wrong with our present contract except that it does not reward us sufficiently for our rapidly increasing work load. The basic idea of a per caput payment is a good one and I personally cannot see anything else being practical or workable considering all the facets of our work. What is needed is a realistic payment for out-of-hours duties, and this must include every weekend from 12 noon on Saturday and must run from 7 pm at night and not 11 pm. This must be a reasonable professional fee for a professional responsibility. Then and only then will the Government, and in turn the patient, realise our worth.

I personally work an eight-hour day from 8.30 am to 6.30 pm. I, of course, have a two-hour lunch break and if I did not I would want to take up alternative employment. What really upsets me is being hauled out of my bed or having to work after my day's work is over for no payment or a payment that is derisory.

Let us opt out of *all* out-of-hours commitment until we are paid what we are worth. The Government can then agree or provide an alternative service—for example, a deputising service. I know that we will all live longer and enjoy our work more.

Let us not "throw the baby out with the bathwater" in our negotiations on a new contract. Let us keep what is a good system and one that has worked for all these years. What we *must* have is a realistic payment for our night and weekend work or, as is our perfect right, opt out of it completely.

D C HOGG
Bristol

"The Way Forward"

SIR,—It is difficult to accept that Mr J A Girling (25 March, p 790) seriously disagrees with DHSS policy regarding allocation of resources.

No one can argue that the pressures arising from continuous increase in population of the elderly loom very large in the problem of achieving a balanced allocation of resources. It is estimated that the number of over-75s, who are the heaviest users of health and personal social services, will rise by half a million over 10 years from 2·3 to 2·8 million. The data quoted by Mr Girling serve to emphasise this point further. It must be conceded that the policy as outlined in *The Way Forward* has been based on a very careful examination of Health Service requirements, considered as a national strategic problem, and therefore the result of thorough and well-informed deliberations, the emphasis mainly being on increased rationalisation in the use of available resources and more effective use of available staff.[1]

It is true that continued development of acute services is essential, but it is not suggested in *The Way Forward* that these services should be drastically cut; the suggestion, rather, is that in view of the growing demand on the available resources for the care of the elderly allocation of resources must inevitably suffer to some extent owing to the need for overall rationalisation because of the financial constraints.

Few areas have enough geriatric beds in general hospitals with immediate access to diagnostic, therapeutic, and rehabilitation facilities; the presence of acute geriatric beds in a general hospital enhances liaison between geriatric medicine and other specialties, which in itself contributes to better use of available resources.[2] This is likely to achieve improved care of the elderly in general, as very often they have multiple diseases, including possible acute surgical conditions. Improved care of the elderly not only increases turnover, reduces waiting lists, and prevents irreversible deterioration of the patient's condition, but also prevents the blocking of other beds, including acute surgical.

The above measures should not only serve to nullify the effects of any marginal cuts in provisions for acute services as outlined in the DHSS documents but would also benefit the elderly considerably.

N K CHAKRAVORTY
St Luke's Hospital,
Huddersfield

[1] Department of Health and Social Security, *Priorities in the Health and Social Services: The Way Forward*. London, HMSO, 1977.
[2] Department of Health and Social Security, *Priorities for Health and Personal Social Services in England*. London, HMSO. 1976.

Wasted women doctors: a fallacy

SIR,—Dr Peter Richards states (14 January, p 95): "To *marry* the *career aspirations* of *women doctors* with their *domestic responsibilities* has proved both too difficult and too expensive for Britain" (my italics). "Misuse of language pollutes thought," and his statement must be corrected lest it harm not only the future contribution of women in medicine, but, in so doing, the medical profession as a whole.

(1) "Marry," as a metaphor of marriage brokerage between two concepts, is confusing here where the marriage of women to men is obviously relevant. (2) "Career aspirations" are what women who choose to be mothers naturally eschew while remaining dedicated to the practice of medicine. (3) The accepted term is "medical women," as in Medical Women's Federation. (4) "Domestic responsibilities" are borne by both men and women—many a medical man has given up career aspirations, without giving up medical practice, because of his domestic responsibilities. Isn't it the "maternal responsibilities" of some medical women which are irritating our postgraduate sub-dean? His assertion now