ing. Medical journals in particular should stop immediately the implicit advertising of alcohol which often appears in their pages concerned with eating out and such recreations. It is not long since in Birmingham the BMA itself arranged a whisky tasting evening.

On the other hand, with heroin we have created a "pushers' market," and our methods for handling this problem are those which have proved disastrous in America in respect of the prohibition of alcohol. In the case of alcohol and of heroin we should set about creating a proper social atmosphere and the attitude that the use of these drugs is despicable. The use of alcohol being so disastrously established in society, we should try to check its use by severe fiscal measures and by legislation against any form of advertising. The so-called hard drugs might best be made available at a cost which will not provide anyone with a motive for pushing; they should be sold unromantically packaged in containers marked "drugs for dopes," and it should be made as inconvenient to obtain them as is compatible with the determination not to create an interest for drug pushers. Individuals have to be responsible for themselves and take the consequences of their foolish behaviour. At least a heroin addict is not likely to cause the death of anyone except himself and in this differs radically from the alcohol consumer.

KEITH NORCROSS

Department of Accident Surgery and Orthopaedics,
Dudley Road Hospital,
Birmingham B18 7QH

Vancouver style

SIR,—Most authors and readers will be grateful that so many journals are adopting a uniform style; but is it too late to plead for the sensible usage of the *Journal of Paediatrics*, which gives a list of all abbreviations used in the text in a box on the first page of each paper?

This may be an extra chore for authors, but it is a tremendous boon for readers, particularly those who need to skim through a large number of journals to pick out which papers need to be read carefully.

PAULA H GOSLING

Mount Pleasant Hospital,
Hastings, Sussex TN35 5AA

Disinfection with glutaraldehyde

SIR,—Following the expiry of the patent on 2% activated alkaline glutaraldehyde, a number of other glutaraldehyde products have appeared on the market. Simple tests suggest that some of these products are corrosive to certain metals and may cause damage to other materials. Glutaraldehyde is commonly used to disinfect expensive instruments—for example, endoscopes—and it is important to check with the instrument manufacturer the suitability of the compound before use.

Glutaraldehyde compounds are either acid or alkaline and may or may not require activation. Although all seem to be effective against vegetative organisms, and claims made by manufacturers for sporicidal activity are generally acceptable, the acid glutaraldehydes tend to be less active at room temperature but more stable than the alkaline. Claims of activity remaining for 14 to 28 days after activation depend not only on stability but on the extent of dilution, the addition of organic materials, and pH changes. Continuous heavy use of a disinfectant solution for 28 days would considerably increase the risk of inactivation. We believe that repeated use of the same disinfectant solution is undesirable, but recognise that it may be necessary on grounds of expense. We are loath to recommend the repeated use of a solution, however stable, for more than seven to 14 days.

We should also like to remind readers that most reusable items, other than those used in surgery such as laparoscopes and arthroscopes, do not require sterilisation. Most equipment, apart from flexible fibreoptics, can be disinfected by heating to over 70°C, either in a washing machine or in a low-temperature steam autoclave without formaldehyde.

G AYLIFFE
B J COLLINS
J R BABB

Hospital Infection Research Laboratory,
Dudley Road Hospital,
Birmingham B18 7QH

Safety of piped medical gases and electromedical equipment

SIR,—Following reports on accidents with anaesthetic and pipeline equipment at the Westminster and other hospitals, there has been much activity by many people intending to improve the safety of design and service maintenance of this equipment throughout the country. The new British Standard for pipeline terminal outlets, which are known as Mark 4, has been published and one hopes that this will improve safety.

Up and down the country many hospital engineers have already sought to make improvements of the piped medical gas installations by means of installing isolating valves and making other alterations. The awareness of the importance of tightening up on the efficiency of service maintenance of anaesthetic and allied equipment has been noticed in the engineering, supplies, and medical disciplines. Unfortunately in some areas, and with the best of intentions, hospital engineers have made decisions affecting the policies concerned in obtaining these improvements without consultation with the medical and nursing staff who actually use the equipment.

It should be understood that final responsibility for what happens when a patient is treated rests with the person prescribing and administering such treatment. The final responsibility for the policies aimed at achieving safety and any changes in these policies must therefore be made either at the instigation, or with the prior approval, of these clinicians. Few of the recent publications give didactic advice on the precise nature of the interface between the clinician and the engineer. Only too often a glib statement that circumstances will vary from one hospital to another has been made, and the responsibility is thereby avoided. I feel that it should be accepted that a named member of the medical staff for each hospital or discipline therein should at all times be consulted whenever a decision with regard to the policy, rather than mere supervision of service maintenance, is considered.

At the time I write this letter the British Standard No 5724 is likely to be published in the very near future. This standard refers to safety of electromedical equipment. It would be well to point out that the publication of a new standard does not on its own require that all electromedical equipment in hospitals must be immediately made to comply with it or be replaced. There will be need for considerable discussion between the medical and engineering disciplines in order to decide what action, if any, needs to be taken to bring existing equipment to a safe standard. Those items which comply already with either HTM8 (Hospital Technical Memorandum No 8) or the recommendations of IEC 601/1 (International Electrotechnical Committee No 601/1) should require no alteration.

C S WARD

Department of Anaesthetics,
Royal Infirmary,
Huddersfield HD3 3EA

Non-motile sperms persisting after vasectomy: do they matter?

SIR,—We would like to comment briefly on points raised by Professor J P Blandy and others (24 February, p 552) about our paper (13 January, p 87).

Firstly, the use of vital dyes: these dyes may indeed indicate that some non-motile sperms are not quite dead, but this is a needless elaboration. If non-motile sperms do not, when put to the test, cause pregnancies their ability or inability to consume oxygen or take up vital dyes is unimportant.

Secondly, Dr P M Hendy-Ibbs (24 February, p 552) correctly states that we have not proved our hypothesis. This is a philosophical objection: we deliberately formulated our hypothesis in Popperian[1] terms. If deliberate attempts have failed to disprove it then it is tentatively acceptable. We claim no more and would welcome attempts by others to falsify it.

Finally, the wife of Mr R H Whitaker describes a patient (24 February, p 552) whose wife became pregnant a few months after his postvasectomy seminal assays had twice shown complete azoospermia, with a few non-motile sperms being found three months after conception. This is a classic example of temporary recanalisation, as described by Marshall and Lyon,[2] in all of whose cases the vasa had been ligated with non-absorbable sutures. It would be of interest to know whether that also applies to Mr Whitaker's case. However, apart from confusing the issue, such a case is irrelevant to the question as to whether non-motile sperms can cause pregnancies.

IAN S EDWARDS
JOHN L FARLOW

Cronulla 2230,
New South Wales

[1] Popper, K P, *The Logic of Scientific Discovery*. London, Hutchinson, 1975.
[2] Marshall, S, and Lyon, R P, *Journal of the American Medical Association*, 1972, **219**, 1753.

**This correspondence is now closed.—ED, *BMJ*.

Induction of labour and postpartum haemorrhage

SIR,—Mr P R S Brinsden and Mr A D Clark (23 September, p 855) and Mr I Z MacKenzie (17 March, p 750) have reported increased incidences of postpartum haemorrhage following induced labour compared with spontaneous labour. In contrast to these reports, we found, in a randomised controlled trial,[1] that patients