Emphasising the grim outlook for most patients with ovarian cancer, you finally urge "a combination of surgical expertise and determined chemotherapy."

This letter, however, is prompted not by the wish to offer congratulation—my first, premature impulse—but to express my dismay that you could so conspicuously ignore the role of radiation treatment in ovarian cancer. I am in no way implying that radiation treatment is the answer to this grave problem, but it is at least as effective as the available chemotherapy. Radiotherapists have long been eager to exploit any combination of therapeutic attacks which might improve the efficacy of any one regimen. But your leading article displays a limited field of vision which is to be deplored rather than congratulated.

ERIC EASSON

Disley, Cheshire SK12 2BB

Cubital tunnel syndrome

SIR,—In your leading article entitled "Cubital tunnel syndrome" (25 August, p 460) you kindly referred to my work on the ulnar nerve. I hope you will allow me further comment on the matter. Opinion is by no means unanimous about the best management of ulnar nerve lesions at the elbow, and the clinical neurophysiologist is apt to see some of the less happy results of the unfettered play of personal preference.

Anterior transposition gives rise to far-from-negligible morbidity in the form of persistent painful paraesthesiae, and often exquisite tenderness in the neighbourhood of the scar, symptoms which may be regarded by the patient as worse than those which first brought him to the surgeon's attention. Are these due to imperfect technique? I have encountered the view that this is a relatively easy operation which can safely be left to unsupervised junior colleagues, but am obliged to note that some transposed nerves can be found a year later lying directly medial to the medial epicondyle, others appearing never to have left the sulcus. Given that transposition, even in the best hands, is not exclusively beneficial, one is surely bound to abide by logical indications for the operation, which seem to be, firstly, deformity of the elbow joint such that the altered relationship of the nerve to its bed makes spontaneous recovery virtually impossible; and, secondly, progression of the lesion in the face of conservative measures or simple decompression.

Conservative measures (avoidance of leaning and unnecessary or repetitive elbow flexion and the wearing of a night splint to prevent full elbow flexion during sleep) are successful in many patients with a history of acute compression or occupational trauma. Decompression is indicated in the spontaneous, insidious case in which the mechanism is likely to be analogous to that of the carpal tunnel syndrome. The more recently developed procedure of interfascicular neurolysis, so fruitful in prospect, is reported to make most patients worse (Trojanborg *et al*, personal communication).

Finally, I beg to differ from your conclusion that no improvement can be expected for at least a year after transposition. This is unduly pessimistic, for relief of sensory symptoms can occur within a surprisingly short time, almost immediately in some cases, and improvement in the use of the hand may be experienced

long before clinical or even electrophysiological recovery is detectable.

J PAYAN

Guy's Hospital,
London SE1 9RT

Consultant contract proposals

SIR,—In a recent letter to its members the Hospital Consultants and Specialists Association welcomed the news (15 September, p 685) that the BMA negotiators have taken a step in the right direction in their attempts to improve the terms and conditions of service of consultants. However, the proposals have some way to go before they meet the three main principles on which HCSA policy on contracts is based.

Our first principle is "The notional half day should be properly priced"—the proposed changes in the current consultant contract do not meet this principle, since the notional half day will remain at less than 70% of the price it should be if 1970 is taken as the base line. This is the year chosen by the Clegg Commission on Comparability for its deliberations on remuneration of other employees in the National Health Service. Our second principle is "Equal work must command equal pay"—considerable advance has been achieved towards this principle. The third principle is "Every consultant must have the right to free time and the right to dispose of it as he wishes, without restriction"—this has not been met by the agreement that whole-timers may undertake private practice as long as the fees do not exceed 10% of their NHS salary. We are pleased that some whole-timers are going to be allowed to supplement their salary with private practice, but why the restriction?

Of equal concern to us is that whole-timers who are unable to carry out private practice can only supplement their income by working a 12th session for the NHS. Surely it is time that agreement was reached on a five-day week and then these consultants will have free time to offer the NHS.

It has been stated that "the Review Body has never yet taken private practice earnings into account in assessing consultant pay."¹ The 1974 Review Body Report² appears to have been overlooked, in which these earnings were indeed taken into account to refute HCSA evidence that general practitioners' earnings were higher than those of consultants."

It is also difficult to accept that terms and conditions of service can in fact be "agreed" by direct negotiations if it is then necessary to submit joint evidence to the Review Body in the hope of stimulating an acceptable pricing. This is particularly important, as there is nothing in Mr Patrick Jenkin's letter to prevent the devaluation of all NHS whole-timers' salaries because some of them may be earning additional fees from private practice.

The HCSA was most pleased that the negotiators had achieved, in principle, everything for which they had asked. However, this knowledge must inevitably prompt the question of why only these changes were sought, since they fall short of basic principles already established by both the BMA and the HCSA.

A B SHRANK

Chairman, HCSA Executive Committee
Ascot, Berks SL5 7EN

¹ Letter from Mr David Bolt to Senior Hospital Staff, 13 September 1979, para 1(e).

² Review Body on Doctors and Dentists' Remuneration, Fourth Report, 1974, para 21.

SIR,—I should like to support the comments of Mr B A Ross (15 September, p 676) on the divisive effects of the proposed new consultant contract which looks likely to be agreed between the BMA and the DHSS without time for proper consideration and discussion. The present proposals appear to offer an automatic 1/11th pay rise to the maximum part-timer, without any change in his or her actual work; whereas to achieve the same rise the whole-time consultant will either have to negotiate an "exceptional" 12th session (and one can imagine how easy that will be) or set up to do private practice, which may be unavailable for the reasons outlined by Mr Ross. I can see no justification for thus increasing the accepted differential in favour of the part-time consultant, when it is in precisely those specialties (including academic posts) in which whole-time practice is common that recruitment is poorest.

The only hope is that practical implementation of the proposals will be delayed long enough for these points to become clear, since the negotiators seem to have repeated the blunder of the spring and agreed a pay increase with no money to fund it. Where is the £500 000 to £3 000 000 going to come from?

G M STERLING
Consultant Physician

Hampshire

SIR,—The results of further attempts to alter the contracts of NHS consultants are now available and are being presented to us with a degree of enthusiasm which appears to me and to many of my colleagues as naive in the extreme. I take leave to doubt that the implementation of these suggestions will have the effect of producing a significant improvement in the morale of many consultants.

The proposals for changes in the part-time contract are, to say the least, unclear. The implication in paragraph 3(c) of Mr David Bolt's letter is that almost all the present maximum part-time consultants will receive payment for an extra session without taking any extra commitment at all. On the other hand, the letter of the Secretary of State and the circular from the Hospital Consultants and Specialists Association imply that additional NHS work would have to be arranged in most cases, and that the proposals do not offer an automatic 11% rise. This discrepancy in interpretation should be cleared up as soon as possible.

The whole-time consultant on the other hand is offered the opportunity to make more money by undertaking additional work in private practice, if he can find it. On this proposal the following matters deserve consideration.

(1) What evidence is there that the majority of whole-time consultants want this right? I have no recollection of having ever been asked.

(2) In many areas and several specialties there is little or no opportunity for private practice, and in the case of specialties in which the work would of necessity have to be done on hospital premises is there any assurance that obstruction by militants would not prevent such work being carried out?

(3) I refer you to motion 445 at the 1979 ARM of the Association—"That private patients should be entitled to investigations and prescriptions under the same financial terms as NHS patients." Implementation of