and for adults with alimentary dysfunction.² (The highly soluble phosphate is absorbed rapidly over a wide area of mucosa and its clinical effect in rheumatoid arthritic patients is of similar duration to that following ordinary prednisolone.) The measurement of free corticosteroid hormones in urine, as a means of assessing their bioavailability, was recommended² and precise gas chromatographic techniques were subsequently described.³

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¹ West, H F, *British Medical Journal*, 1959, 2, 680.
² Bailey, E, Murphy, D, and West, H F, *Archives of Diseases in Childhood*, 1963, 38, 71.
³ Bailey, E, *Journal of Endocrinology*, 1964, 28, 131.

The surviving twin

SIR,—The question and answer (7 April, p 934) on psychological reactions in a surviving twin were of great interest to us, as we are concerned with a similar case at present.

This case, which is being described in more detail elsewhere, involved a surviving twin following a sudden infant death ("cot death"). The mother complained that the survivor was "possessed" by the spirit of the dead twin, and that this was causing his "naughty" behaviour. Psychiatric assessment disclosed that this was not a true delusional belief, but an explanation given by the mother in the face of difficult and unmanageable behaviour.

In fact, since the cot death two years ago, she had severely rejected the surviving twin. He was recently admitted to hospital when it was discovered that she was locking him up, and he was felt to be at risk. The problems of a very complicated domestic and social background could not be readily resolved and the child is now in foster care.

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Cervical cytology

SIR,—I was interested to read Dr R E G Sloan's letter (19 May, p 1356) concerning the reliability of technicians' reports on cervical smears. He complains that in one centre there were too many requests for repeat smears whereas in another comments were confined solely to the presence or absence of atypical cells.

In order to receive reliable reports it is essential that the specimens are collected correctly. A cervical scrape should include the squamocolumnar junction as this is an important site of origin of intraepithelial neoplasia. A satisfactory cervical scrape therefore must contain endocervical cells, usually in sheets. In only 5-10% of women, mainly those in the older age groups, the squamocolumnar junction is displaced and out of reach. While the absence of endocervical cells is of no particular importance in a "positive smear" a negative smear is unreliable unless endocervical cells are present and requests for repeat of such films are absolutely justified. I suggest that if Dr Sloan and his colleagues revise their smear-taking techniques the number of repeat smears will be drastically reduced.

With regard to his second complaint, I would like to point out that Dr Sloan confuses the task of the screener in population-screening centres with that of the cytopathologist, whose diagnostic scope extends far beyond the recognition of dysplasias and intra-epithelial carcinomas of the cervix. That the screeners are highly successful in their laborious efforts of reading large numbers of slides is evidenced by the declining incidence of invasive cancer of the cervix and its falling death rate. Incidental findings such as trichomonal, monilial, and herpetic infections are usually also reported but are not the main concern of the screener.

It is grossly unfair to submit buccal and nasal smears labelled as cervical scrapes to a screening centre and to expect the screener to recognise the ruse. The technician in the Gloucestershire laboratory would, in all probability, have rejected the smears and asked for a repeat—but then Dr Sloan complains about such a request. The Yorkshire laboratory stating that there were no malignant cells in the specimens submitted is probably right and Dr Sloan should feel reassured about the state of the epithelia in his buccal and nasal cavities.

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Blood transfusions and Jehovah's Witnesses

SIR,—Adult Jehovah's Witnesses, who refuse to receive blood and blood derivatives, may sign a form accepting full responsibility for their action. This release of medical and administrative staff from responsibility is acceptable so long as the patient is not subsequently rendered unconscious (and therefore unable to change his mind) by the administration of an anaesthetic for which he has given his signed consent. This consent should not be conditional on the non-administration of blood as it imposes an unacceptable burden on the anaesthetist, in whose care the patient has placed himself while unconscious.

I recently anaesthetised a Jehovah's Witness for an emergency caesarean section. During the procedure she developed diffuse intravascular coagulation and I had to abandon the unequal struggle with fluids and plasma expanders and resorted to fresh frozen plasma and 8 units of blood. The patient survived and she accepted, with regret, the need for the transfusion.

As often happens, a week later another Jehovah's Witness needed anaesthesia for examination for possible placenta praevia. When I gave an undertaking not to give blood except as a last resort, there was a hysterical response from both the patient and her husband with an absolute refusal of any blood under any circumstance. In the interest of the patient, I eventually made all the necessary promises and proceeded to anaesthetise her for examination and eventual caesarean section as I had done in the past—that is, agreeing not to give blood but prepared to do so if absolutely necessary.

Jehovah's Witnesses seem to be impervious to the problems they create for the nursing and medical staff (the anaesthetist in particular) by merely signing a quasilegal document. I therefore wonder whether I should carry on as in the past, and possibly be sued if I give blood when I consider it life saving, or whether I should also draw up and sign a quasilegal document agreeing to administer anaesthesia

without this absolute restriction. I would be grateful for a legal opinion and the view of any medical practitioners who are Jehovah's Witnesses.

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Medical reports and confidentiality

SIR,—I was interested to read the letter from Drs G B May and W P Garson (26 May, p 1427) and welcome the most enlightening reply from Dr David Gullick (16 June, p 1631). As a physician with an interest in life insurance medicine may I stress that the insurance company is only too anxious to give the patient the best possible deal—maximum cover for minimum outlay—and, further, that requests for medical attendants' reports are made as much for the benefit of the insured as the insurers. As Dr Gullick so rightly points out, this information is the property of the patient, who always gives permission for its disclosure.

On receipt of the request from the patient for insurance cover the underwriters' task is to assess any increased risk to life posed by past or present disease, and this may lead to an increased premium if the fit members of society are not to subsidise the unfit. Accurate assessment of risk may be difficult even when all the medical facts are known, but how much more difficult when they are not. In this latter situation the assessor may have to impose an extra for uncertainty, which might not exist were fuller information available. If there is any doubt about the histology of an excised lesion, the cause of an episode of jaundice, or whether the suicide attempt was genuine the premium may well be loaded; if on the other hand it is clear beyond doubt that the polyp removed was benign, that the jaundice was infective and not alcoholic hepatitis, or that the suicide attempt was just a simple call for help the premium may be normal or the loading minimal.

The medical examiner's report, although very helpful with regard to the current situation, cannot possibly give overall information to the same degree of accuracy as a medical attendant's report—particularly as the patient himself may be unaware of the exact nature of a previous illness. The insurance company is as concerned with the patient's welfare as is his doctor; and any general practitioner who refuses to disclose information requested by a Life Office for the purpose of insurance, far from helping his patient, may be doing him a positive disservice.

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Small hospitals and the nursing shortage

SIR,—I would like to draw attention to a parochial matter in north-west Surrey which could have serious implications nationally.

On Wednesday 30 May, the chairman of the medical staff of Walton-on-Thames Hospital received a telephone call from the district management team for north-west Surrey to say that from the following Sunday the women's ward of Walton Hospital would be closed for seven weeks. A similar call was received at the neighbouring Weybridge Hospital, with the added information that the casualty services at that hospital would be

restricted. A total of 32 beds were to be closed so that the nurses could be transferred to the district hospital because of an acute nursing shortage. Prior to this decision (made in the absence of the GP member of the DMT) no consultations whatsoever took place with the general practitioners, who were suddenly confronted with the prospect of seeing nearly half their hospitals closed at a stroke. No assurance has been given that the wards will be reopened after the appointed time. Even more disturbing is the fact that the nurses at these hospitals had previously been interviewed by the district nursing officer and asked if they would be willing to help out by working at the district hospital and advised not to discuss the matter with anyone else.

It is not the purpose of this letter to harp on such misguided and discourteous mismanagement, a matter which must be sorted out in due time locally. Nor is it to disclaim the duty of small hospitals to support the district hospital's acute services in times of crisis, or even from time to time on a properly planned basis (the impending shortfall in nurses in north-west Surrey had been recognised for three months). What I wish to make clear is that the closure of beds at peripheral hospitals does nothing in the long term to solve the problems of nurse shortage but rather to aggravate them. The reason for this is that a large number of those who work in the small hospitals choose to do so for convenience and practicality. Without the presence of the small local hospital their services might well be lost altogether. Attempts have been made in north-west Surrey to introduce a clause into nurses' contracts wherein they promise to work at any hospital in the district rather than a specific one. I fear that such a policy would be self-defeating because many nurses would choose not to work at all rather than commit themselves in this way.

There are some 350 GP hospitals in England and Wales, which are with official encouragement assuming their proper role in the overall pattern of hospitals. One of their major contributions is the provision of local nursing care. These hospitals are small and therefore still vulnerable. District management teams in wielding the power of responsibility must remember that, whereas two wards in a district hospital represent a fraction of the whole, the closure of whole wards in hospitals with a total of 35-40 beds total is seen as a major calamity locally, and even if not intended to do so could lead to the destruction of those hospitals. Such action could serve to reduce rather than increase the total number of working nurses.

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A "specialty" for second-class doctors?

SIR,—I have recently been reading a document entitled *Criteria for the Selection of Trainers in General Practice*, issued by the Joint Committee on Postgraduate Training for General Practice.

Great emphasis is laid in this publication on the use of self-assessment as a clinical teaching tool, on the need to be able to form harmonious relationships with patients and colleagues, on the need to understand the patient's interpersonal relationships, on the need to understand social and environmental factors. When it comes to the area of clinical competence, the document becomes vague.

Nowhere is it mentioned that the trainer should be able to carry out thorough clinical examination in all specialties; nowhere is it mentioned that the trainer should have a thorough knowledge of therapeutics and the side effects of all available drugs; nowhere is it mentioned that the trainer should be competent in simple clinical procedures and in the use of such diagnostic equipment as ECGs.

There is no doubt that general practice needs to put its house in order, but it is noticeable that the great majority of doctors over the years have been held in high regard for their sympathetic handling of their patients. It is in the area of clinical competence where our deficiencies have been so blatant, which has led so many of our patients to regard the GP as the second-class doctor and the hospital specialist as the first-class doctor.

I would be interested to know if there are many doctors who, like me, believe that by making vocational training mandatory we have sold the soul of our profession to a highly motivated minority, who may take a totalitarian stranglehold on us and lead us down the wrong road. Shall we not merely deter the highly qualified senior registrar or registrar from making the switch to general practice and condemn ourselves for ever to be the second-class doctors?

My critics may say that general practice must now be considered a specialty in its own right—namely, "primary care," which is the fashionable terminology. But many may believe, like me, that this is a contradiction in terms and that "general practice" is a discipline that runs in partnership with "hospital practice," within which all the specialties exist. Or am I a lone voice crying in the wilderness?

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New consultant contract

SIR,—The new consultant contract is beginning to resemble a tower block: it gained great acclaim for its architects, but nobody wants to live in it. On the assumption that we should start again, may I offer a few thoughts?

Firstly, in industrial terms, it is nonsense to have a wage structure which depends on overtime (recall fees and other extra payments) to achieve an adequate living wage. This could give people a vested interest in not improving a service in which their income depends on a deficiency of junior staff. It should have been obvious, in any case, that no one would repeat the UMT farce a second time, though it was a surprise to find the recall fees priced below that of a plumber's visit. What is clearly required is an adequate basic salary, irrespective of specialty, so that gross inequalities between consultants in different specialties are avoided and recruitment can be maintained in those specialties with little emergency work. Having been one myself, I have every sympathy for the overworked regional (that is, non-teaching) hospital consultant; but I would have infinitely preferred adequate junior staff and satisfactory working conditions to additional payments. Advisers appointed by the Royal Colleges to sit on appointment committees should exercise their right more frequently and more forcefully to tell employing authorities that a particular post is unsatisfactory.

Secondly, in any future negotiations it is to be hoped that our negotiators do not abdicate

their responsibilities to negotiate. In the new consultant contract the negotiations for the extra NHDs would have been left to an individual argument between *each* consultant and the employing authority, which puts the consultant in a ridiculously weak bargaining position, and leaves the RHAs and AHAs with the task of negotiating hundreds of individual contracts.

Thirdly, it was naive to build into the new contract the assumption that every consultant would be doing private practice. It is obvious that at some stage the DHSS or the Review Body would take into their calculations on the basic salary the fact that additional money could be earned in private practice. The facts are that in many specialties and in many areas private practice is simply not there to be had. Moreover, many consultants prefer to concentrate on hospital work, without the distraction of other commitments.

Finally, I was depressed to see that the profession is now pressing for more facilities for private practice. We are already dangerously near a "two-tier" system. If we, as a caring profession, wish to retain a hospital service which is for everyone, we should be working towards improving it rather than setting up a competing parallel private service. If our hospital service deteriorates any further, it will be a poor man's service and the articulate (who can complain) will forsake it. So far no politician has had the courage to tell us what it would cost in additional taxes to fund the NHS adequately. I believe that the public would choose to pay more for a better service if the facts were presented to them clearly and honestly.

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Review Body Report

SIR,—A close reading of the 1979 Review Body Report reveals a difference of understanding between the Health Departments and our negotiators on several very important issues.

Paragraph 22 of the report states: "The Health Departments indicated that it was not the intention to provide additional funds to cover recall fees, but the profession assumed that, as the Government had agreed to the introduction of separate payments, it would be prepared to make financial provision for them." And later in the same paragraph, in referring to the pricing of the new contract, the report states: "It had not been established clearly between the parties whether or not extra provision would be made to cover the cost of paying separately for work which was covered by the previous contract, but which under the new contract would attract separate payment and was now being described by the professions as 'new work.' The professions assumed that such provision would be made, but the Health Departments assumed that, where the source of finance had not been identified, the professions were content for the cost of each item to be found within the overall cost of the new contract."

Surely this vital series of understandings, presumably agreed at meetings, were confirmed in approved minutes written after the meetings. There must be written evidence of such understandings, and it would be most appropriate for this evidence to be published so that the profession can lay the blame for the disastrous report, so far as consultants are concerned, on the party responsible. If the