oestrogens should be given to keep their sexual development level with that of their peers. In this way, much unnecessary extra stress can be avoided.

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¹ Brook, C G D, *et al*, *Archives of Disease in Childhood*, 1974, **49**, 789.

Urinary incontinence during treatment with depot phenothiazines

SIR,—I was most interested to read the letter from Dr A Shaikh (24 June, p 1698) on urinary incontinence in women under treatment with depot phenothiazines. In 1967 Brocklehurst and Dillane¹ reported that anticholinergic drugs had been shown to increase functional bladder capacity by 50 ml or more in individual women suffering from urinary incontinence.

In view of the fact that anticholinergics such as orphenadrine hydrochloride are widely used to control the extrapyramidal reactions sometimes associated with the use of major tranquillisers it may well be that this use could be extended to include the control of urinary incontinence where this is a problem.

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¹ Brocklehurst, J C, and Dillane, J B, *Gerontologia Clinica*, 1967, **9**, 182.

Who decides? Patterns of authority

SIR,—Of all the contributions to your journal to mark the 30th anniversary of the NHS, that of Professor Rudolf Klein (1 July, p 73) goes to the heart of the matter. Professor Klein mentions that the medical profession has always insisted on participation. The re-organisation of the Health Service with its three-tier system was simply a response to trends in greater participation for workers in decision-making. Further, if the Royal Commission were to respond to further demands for worker participation, surely more tiers would have to be added rather than deleted to encompass the proliferation of consultative committees which has already slowed the process of taking decisions (leading article, p 1).

This is, of course, only one of the problems that face the NHS, but it is one that the medical profession can do something about at once. Are its members prepared to resign from their positions in the non-statutory consultative committees to bring about the collapse of the tyranny of rule by committee? Ah, the deafening silence!

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Negotiating rights for hospital junior doctors

SIR,—It is a matter for considerable regret that the excellence of Mr J N Johnson's performance in the chair at the Hospital

Junior Staff Conference (8 July, p 144) should have been marred by charges that he was party to preplanned filibustering to prevent debate on Motion 104. Whether the alleged filibustering was real and whether he and the other officers of the conference were party to it will doubtless be the subject of rancorous reverberations in the medical press and, worse, another source of division among juniors. As chairman of the North-west Regional Hospital Junior Staffs Committee, where Motion 104 originated, I write to explain why this region believed the motion to be important and opportune.

The motion read: "That the national HJSC should offer to the Medical Practitioners Union/Association of Scientific, Technical and Managerial Staffs and the Junior Hospital Doctors Association a number of voting seats on the HJSC (to be filled by hospital junior doctors), a number of non-voting seats (to be filled by principal officers, advisers, or full-time officials), and a role in the servicing of the committee if they will in turn accept the HJSC as the negotiating body."

The HJS Conference's rejection of the Review Body was widely anticipated. Its sequel is uncertain, but is likely to be direct negotiations with the Department of Health and Social Security. Juniors would then require to confront the Department in concert, not as diverse warring factions which could be played off one against the other. Add to this the likelihood of the Advisory, Conciliation and Arbitration Service awarding negotiating rights to the JHDA and MPU/ASTMS and it is clear that juniors are almost certain to need some kind of joint negotiating machinery in the very near future. If this cannot be achieved within the HJSC a new structure will be necessary—a joint negotiating body comprising representatives from the different organisations. This structure would be less efficient than the negotiating rights being contained within the HJSC as it would involve much coming and going between the negotiating body and the HJSC and its equivalents in the JHDA and MPU/ASTMS to thrash out a common policy.

How are the JHDA and MPU/ASTMS to be persuaded to abandon their claims to separate negotiating rights? Perhaps it will prove impossible (and there are cogent arguments for their staying aloof as critical ginger groups, as the Liberals have found through their involvement in the Lib-Lab pact); but if it is to be achieved, it will only be through real involvement in the HJSC. Motion 104 was intended as a basis for further discussion, nothing more.

It is natural that the BMA is reluctant to share the power it now has and perhaps run the risk of improving the competitive position of its rivals, but if the result is to strengthen the HJSC and make it more representative of juniors the gains might well outweigh the losses. In addition, if the BMA gives real substance to the proposed strengthening of its peripheral structures it will become more meaningful to the average junior doctor and, ipso facto, a colossal threat to its rivals.

As Motion 104 will now be referred to the HJSC for consideration I hope that the above will help to reduce the emotion now surrounding it, allowing it to be evaluated on its own merits in that forum.

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"Proceed with the pricing"

SIR,—As you rightly say in your leading article (1 July, p 4), new contracts require pricing. It must be remembered what we as consultants are giving. We are now going to give a full 3½ hours' work as a session as opposed to what is for the majority of present consultants a session which includes travelling time to work. I would think that at a reasonable estimate most consultants so affected (which is all except the comparatively young) would now be working only a 3-hour session. Under the new contract, therefore, they would be giving 16%, extra time.

In regard to the full-timers, their standard working sessions are going to be 10, apart from the negotiable extras, instead of 11, which is a reduction of only 9%, so that every full-timer except comparatively few recently appointed is going to give the Health Service 7% extra work under the new system. Therefore the rating for the new contract compared with the old full-time payment must be that 7% extra. Obviously the part-timer, working 10 sessions instead of 9, will also have to get a corresponding percentage increase if the new contract is going to mean anything.

Furthermore, the on-call work in the evening as opposed to the on-duty daytime work and the other regular sessions does not seem, so far as I read the contract, to be mandatory, although it is obviously essential to the service. Obviously, therefore, unless the pay for the work done shows a satisfactory increase in relation to other types of work done under contract, there is going to be very little enthusiasm on the part of anyone to do the work, and as on duty does not apply after 7 pm it must be up to the management side to indicate suitable remuneration for this extra work.

Overall, the new contract must not be regarded as benefiting only the consultants. It can be, I think, of very considerable benefit to the service, and I think it might very well very considerably improve, in many instances, emergency care.

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New consultant contract

SIR,—The euphoria surrounding the Central Committee for Hospital Medical Services at the moment seems to be well exemplified by its chairman's address to the Senior Hospital Staffs Conference on 27 June (8 July, p 148).

How he glimpses his "ray of hope" for consultants based on his observations I find very difficult to understand. He attributes the Review Body's recommendations of a percentage salary increase to the influence of the CCHMS on the Prime Minister's thinking. Virtually every pay award to all groups has for some time been percentage-based and there is a hint of presumption in his thinking that the CCHMS played any significant part in this. The new contract proposals accepted by the "overwhelming majority" of 50% of consultants apparently also constitutes an "enormous success." Where he finds the hope that "the proposals would undoubtedly lead to greater financial rewards and greater freedom and independence for consultants" is again difficult to understand.

The most disturbing conclusions which one must reach from this optimistic euphoria is