to necrosis with granulocyte infiltration—were found. The lungs showed chronic venous congestion in addition to the acute congestion. There were stones in the gall-bladder and microscopy showed chronic cholangitis.

In view of the changes these oral contraceptives may cause in the blood coagulation mechanism,¹ and in particular in view of the study in which similar drugs were found to cause thrombi in the hearts of hamsters,² these findings tempt one to postulate that this case may be an example of thrombosis of similar aetiology. The dosage in this case was low, but she was obviously intolerant, as she developed side-effects. Could it be that detoxication of the drugs had been hindered by her liver disease?

It now appears to be accepted that venous thrombosis with subsequent embolic complications may be expected in women on these drugs³ (in, as Tyler⁴ puts it, a state of pseudo-pregnancy), but that the danger is probably no greater than that in pregnancy. However, the present case, and possibly Zilkha's⁵ cases also, indicate that the possibility of arterial thrombosis may also exist. No conclusions can be drawn from single cases, but it is suggested that we should continue to be on the look-out for similar cases, and above all be aware of the possible dangers of oral contraception.—I am, etc.,

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REFERENCES

- ¹ Egeberg, O., and Owren, P. A., *Brit. med. J.*, 1963, 1, 220.
- ² *Ibid.*, 1964, 2, 1089.
- ³ Tyler, E. J., *J. Amer. med. Ass.*, 1963, 185, 131.
- ⁴ ———, *Brit. med. J.*, 1964, 2, 843.
- ⁵ Zilkha, K. J., *ibid.*, 1964, 2, 1132.

Cervical Cytology in General Practice

SIR,—I am prompted by the letter from Dr. Geoffrey C. Rivett (12 December, p. 1531) to give my views on cytodiagnosis and its application to general practice. It has been conclusively shown by the work done in British Columbia and in this country that selective screening is not the answer to the prevention of cervical carcinoma. In other words, it means comprehensive screening or the general practitioners taking smears from every parous patient on their lists from the age group of 25 to 60. The cytologists hope that this would almost eliminate carcinoma of the cervix by 1980.

The practitioners have only to multiply the number of female patients (ages 25 to 60) by the time it takes the women to undress and re-dress to realize the time factor involved. Added to this must be the time taken to complete laboratory forms and dispatch of the slides to the cytological laboratory.

In my opinion, any general practitioner who commences this work without a concrete contract, either from the National Health Service outwith the Pool, or by private arrangement with the patient, for payment for this service, to put it mildly, should seek psychiatric advice. The day for altruism in both the hospital service and general practice is nearly over.—I am, etc.,

RICHARD DE SOLDENHOFF.

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Intravenous Plastic Catheters

SIR,—In our experience with intravenous plastic catheters inserted through a needle we have found that the following precautions are effective in dealing with the dangers mentioned by the secretaries of the three defence societies (19 December, p. 1600).

(1) The needle should be completely withdrawn from the tissues to the end of the catheter against the junction of the catheter and connecting base.

(2) At least one inch (2.5 cm.) of free catheter should be present between the point of the needle and the skin puncture.

(3) The catheter should be taped firmly to the skin by a piece of plaster over the point of entry through the skin.

(4) The needle should also be firmly taped in two places—firstly, across the metal and, secondly, across the plastic wings used for gripping the needle.

(5) The catheter should be replaced completely after three days—at the latest after four days—as we have found that early fractures are present in catheters removed on the fifth and subsequent days.

If the above precautions are followed the likelihood of any fracture occurring in the tissues or in the veins, thus allowing a catheter embolism, is extremely unlikely. Despite almost routine use of these catheters, we have had no complications.—We are, etc.,

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Injuries at Work

SIR,—Your leading article (12 December, p. 1479) on industry and health refers to "the chapter on accident statistics records 204,269 accidents causing loss of working time during 1963," and remarks that greater

success in prevention is imperative. In fact, what the number 204,269 really refers to is the number of injuries which were reported to the Factory Inspectorate and which lost more than three days from work. It takes no account of injuries which resulted in loss of more than three days from work and were not reported (about 40% in 1962), or of the injuries which resulted in loss of one to three days, or of the injuries which occurred but did not, by chance, result in loss of time beyond the day or shift.

What in fact is being recorded is the tip of the iceberg—and in terms which are not only misleading but also tend to minimize the true extent of the problem. This form of approach does not help to produce greater success in prevention. These injuries are not accidental (in the dictionary sense of being "events without apparent cause"), they are caused. Anyone who has investigated the incidents which result in injuries is also aware that in most cases the injury could have been prevented. To continue to talk of accidents with all the connotations and overtones of the unpreventable and the supernatural, when what we really mean is injuries, is to do a disservice to preventive efforts. Just as we cannot deal with an outbreak of typhoid by thinking of it as without apparent cause ("accidental"), or by concentrating on those victims who happen to be brought to our attention and are horizontal in hospital for more than three days ("reported"), but have to look at the vertical cases and at all causative factors, both personal and environmental, and at the mode, place, and time of interaction of these factors, so we are prevented from making progress in an epidemiological approach to the problem of injuries while we use confusing and misleading terms in official reports or in discussions of the subject.—I am, etc.,

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REFERENCE

- ¹ *Concise Oxford Dictionary*, Oxford University Press, Oxford.

The Solihull Stretcher

SIR,—Steep head-up and head-down tilts are required for many surgical, obstetric, and anaesthetic purposes. To secure the patient against slipping off the table under these conditions straps, foot-rests, and shoulder-rests have been advocated, but the least accident-prone method is the corrugated

rubber mattress described by Dr. C. Langton Hewer in 1953,¹⁻³ which allows tilts up to 45°, using skin friction only to secure the patient.

At Solihull Hospital we use a modification of this mattress, not fixed to the table, consisting of two layers of corrugated rubber

36 in. (91 cm.) long by 15 in. (38 cm.) wide, glued together so that it is corrugated on both surfaces. The maximum tilt on our operating table, 33°, is seldom called for, and our short stretcher, placed beneath the trunk of the patient but not under the head or legs, guards adequately against slipping at this maximum tilt.

In our photographed experiment, the Solihull Stretcher was tested under the least favourable conditions, in that the subject wore ordinary operating clothes, the table itself had a smooth rubber mattress, and we interposed a canvas stretcher either next to the patient (as shown in the photograph) or next to the operating table. It functions equally well in the head-up position.

Our stretcher can be used as shown with a canvas stretcher on operating tables, and also on theatre trolleys and obstetric beds, which tilt but do not normally have corrugated surfaces. We have used it for many months for a wide variety of obstetric, surgical, gynaecological, and anaesthetic procedures, and have found it entirely satisfactory and easy to manoeuvre. Its universal application would obviate the use of shoulder-rests, which are dangerous.

We would like to thank the manufacturers and suppliers, Talley Anaesthetic Equipment Ltd., of 505 Liverpool Road, London N.7, for their assistance in the development of this stretcher.

—We are, etc.,

Solihull Hospital,
Warwickshire.

H. B. WATSON.

P. H. DENNISON.

REFERENCES

- ¹ Langton Hewer, C., *Lancet*, 1953, 1, 522.
- ² — *Anaesthesia*, 1953, 8, 198.
- ³ — *Canad. med. Ass. J.*, 1956, 74, 285.

What Should I Do?

SIR,—From time to time I am called upon to conduct a blood-taking session at the midwives' clinic. This is an arrangement which is welcomed by many busy general practitioners and it saves the mothers a journey to hospital.

But at each session I am approached by one or two mothers and their midwives, guiltily asking if I would do a haemoglobin estimation "off the record" as their particular general practitioners "do not believe in haemoglobin tests." I confess that with impassive countenance I oblige, and am then faced with the dilemma of what to do when a low reading is revealed.

Recently I learned that this problem is shared by clinic doctors in a neighbouring county, so it may well be country-wide.

Is it one's first duty to protect the mother, or a fellow practitioner?—I am, etc.,

London S.W.16.

M. J. BALL.

Remedy for Discontents

SIR,—That there is at present great discontent amongst general practitioners in the National Health Service is becoming increasingly clear. I also think it is clear that the somewhat peaceful attitudes of the representatives at the Annual Representative Meeting in Manchester earlier this year does not mean practitioners on the whole are more contented. Rather does it mean that they are waiting expectantly and with possibly more confidence than I have in the outcome of the Review

Body and the Fraser Committee. However, I feel certain in my own mind that the kettle is at present simmering and will soon boil over if results are not forthcoming.

Firstly, we have to decide once and for all whether we wish to be fully salaried or self-employed. My own feeling is that at least three-quarters of us wish to remain self-employed. So many of our grouses are really the concern of no one but ourselves. If we wish to remain self-employed then it is useless to expect the Government to provide us with locums, holidays, deputizing services, premises, cars, and equipment. To my knowledge no self-employed person in the world gets these facilities provided. To ask for them is to accept salaried service as do our hospital colleagues.

I believe that when all is said and done our problems would be largely solved if there were a substantial increase in the basic income of the general practitioner to-day.

I can offer a reasonably simple basic solution to much of the discontent in general practice to-day, which I think would be remedied by the following simple scheme.

(1) All general practitioners should offer to form new contracts with the Ministry of Health on the following broad terms: (a) to provide free treatment for a reasonable week's work—say, 9 a.m. to 6 p.m. each day except on half-days and week-ends; (b) all patients receiving treatment outside the reasonable hours would be free to approach any doctor (it would usually be his own or a deputy arranged by his own doctor). These patients treated out of hours would sign a form which the general practitioner would send to the executive council and for which he would be paid a set fee which would not come out of the Pool. (If you think this is cumbersome let me remind you it works quite well at present with temporary residents.)

(2) The capitation fee is raised to a realistic level at once—to, say, 2 or 2½ times the present capitation fee.

Now I ask you what has happened to our problems? (a) We can now supply out of our own pockets better premises, ancillary help, appointment systems, and spend money on diagnostic instruments. (b) We can form group practices with much better service all round. (c) We can afford study leave, locums, holidays, and time to keep abreast with medical politics. (d) We can put money aside for our own pensions and annuities and for those of our dear wives. We may even live longer! (e) The older or the infirm practitioner can take it easier and do no night work if he so wishes. We can be ill in relative comfort. We can lead a fuller social life and be all the better doctors for it. (f) Deputizing services would flourish and we could all afford them. (g) The doctor who wishes to work 24 hours a day for 365 days a year can still do so and be the better off financially for so doing, as he rightly should be. (h) This I think is very important. General practice would again become a sought after profession and within 10 years of my scheme operating we could expect an easing of the shortage of general practitioners. Young graduates would no longer be shying off general practice. We could even expect immigration instead of emigration.

You will say that this is ridiculous and no Government would accept this. Where are their safeguards? Where is the money to come from? I would reply that we have

gone for years on trust with poor safeguards. We are at the mercy of the Government, the committees, and even our patients. Without the devotion to duty which I sincerely believe is in every general practitioner the service would have floundered long ago, and I believe just as sincerely that this devotion will persist and is quite enough safeguard for the proper and correct treatment of the community.

You cannot keep renovating an old cover—it soon becomes a patchwork quilt. So it is with the health service—let us be bold, resolute, and firm and negotiate from strength. Let us sweep away all the patches of discontent and make a service which, as well as being good for our patients, is also good for us. Let us be proud—and happy to belong to it.—I am, etc.,

London S.E.24.

CYRIL JOSEPHS.

Family Planning under the N.H.S.

SIR,—An account by your Parliamentary Correspondent on "Family Planning under the N.H.S." (28 November, p. 1406) raises most important issues which affect the general practitioner and which I feel should be made clear.

I would interpret the questions asked by Mr. Abse of the Minister to mean, quite simply, that the Family Planning Association (F.P.A.) wish the Government to pay for advice, treatment, and appliances provided to women who are at present treated privately and who themselves pay the cost to the F.P.A. In this area patients tell me that the fee obtained by the F.P.A. for advice and examination is about £2 per year. Contraceptives may be sold by the F.P.A. at a permitted discount rate of 33½%. The discount permitted to the dispensing general practitioner is, at best, 20%. When the grounds for the use of contraceptives are medical and the patient is referred to the F.P.A. their fee may be, quite properly, recovered from the Government and the contraceptive, particularly the oval type, provided free of charge to the patient and again at the expense of the Government.

The very pertinent issues which I feel are involved are:

(1) When the grounds for birth control are social the transaction between the F.P.A. and the patient is regarded as "private," and the patient pays not only for the cost of the contraceptive but also pays a fee. The same patient may be later managed by the F.P.A. at the cost of the N.H.S.

(2) When there is a medical indication recommended by a consultant obstetrician and gynaecologist the Government can pay the whole of the cost of the service provided by the F.P.A., which would otherwise have been paid by the patient. The same patient may previously have been treated on a "private basis."

(3) The consultant would not be required to justify the expenditure to his colleagues.

(4) The F.P.A. is able to provide private and N.H.S. treatment to the same patient at differing times.

(5) The family doctor may choose, and quite properly, to provide comprehensive advice and treatment on birth-control problems. Indeed, his patients may ask that he should do so.

Of the five issues already mentioned only the first could be considered to apply to the