CORRESPONDENCE

Correspondents are asked to be brief

New Health Authority Areas

SIR,—Sir Keith Joseph states in his preamble to the Consultative Document[1] that the public needs and the Health Service demands a service organized so that its separate parts are planned and operated not in fragments but as a whole. For this reason the boundaries of the area health authorities will be the same as those of the counties.

Under this coterminous arrangement west Wiltshire with a population of 185,000, at present in the Bath clinical area, is to become part of the Wessex regional hospital authority, while Bath is to remain part of the south-western regional hospital authority. We are informed that this administrative adjustment will make no difference to medical freedom. What unified service will there be if west Wiltshire is in one area health authority and Bath hospital complex in another? What unified service will there be if 13 west Wiltshire district hospitals are administered by one regional health authority and staffed by consultants from another regional health authority?

The money which would have been available to the south-western regional hospital authority for 185,000 patients will, presumably, now be diverted to Wessex regional hospital authority, and as a result of this the Bath hospital group will be unable to keep abreast of modern development. In the long run there will be a reduction in the efficiency of treatment for Bath patients and a long journey to Swindon, Salisbury, or Southampton for patients inside the Wiltshire boundary. Is this progress?

We in this area, consultants, general practitioners, hospital management committees, and hospital administrators, are fighting this carve up with all the means at our disposal, including coverage from the national and local press, radio and television, and with the assistance and full co-operation of local members of parliament. Are there other areas so involved or are we in a unique position in this country?—I am, etc.,

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1 Department of Health and Social Security, *National Health Service Reorganization: Consultative Document*. London, H.M.S.O., 1971.

After Sterilization

SIR,—Mr. M. J. Muldoon is to be congratulated on his report on 374 sterilized patients (8 January, p. 84). I feel sure he must have posed the question: *without* sterilization how many patients would have developed gynaecological symptoms over the past 10 years? How many patients with an intrauterine contraceptive device or on oral contraceptive would appear in outpatients in 10 years? How many practising coitus interruptus would live in fear of pregnancy? Mr. Muldoon avoids the role of gynaecological soothsayer, though he underlines the need for taking a careful menstrual history before deciding to sterilize when possibly hysterectomy would be a better choice.

It will unfortunately be impossible to compare the incidence of poststerilization symptoms over the past decade with the next since case selection following the 1967 Abortion Act has greatly altered the indications for sterilization. In our unit in Birmingham, for example, nine out of ten laparoscope sterilizations are carried out as a method of permanent contraception in healthy, sexually active women. They have decided their family is complete. The domestic disturbance is much less after laparoscopic sterilization than after hysterectomy, which in our experience usually requires six to eight weeks before full domestic duties can be undertaken without some fatigue. A decision is therefore best made in outpatients so that home-help can be arranged for hysterectomy but not for laparoscopic sterilization, which disturbs the patients for only two or three days at most.

With many thousands of sterile young and not-so-young women ahead of us it is clearly necessary to plan long-term studies prospectively, so that with some degree of confidence one may answer the question, What will sterilization do to me and my marriage?—I am, etc.,

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Best Age for Cervical Smears

SIR,—The observations usually cited in support of campaigns for the early detection of cervical cancer in women under 35 years of age are two: firstly, the number of women aged between 20 and 35 years who are found by Ayre's technique to have intraepithelial cancer of the cervix,[1] and, secondly, the number of women who develop invasive cancer of the cervix before the age of 35.[2] In 1968 the Isle of Man Health Services Board decided to pay general practitioners for taking cervical smears from women of any age, and the Anti-Cancer Association began a campaign to persuade all women between the ages of 20 and 70 years to be examined.

We have found that women of any age are reluctant to volunteer, and with help from grants from the Cancer Research Campaign and the Louise L. Britton Cancer Research Fund we have started a scheme which includes a personal letter from the doctor to all women aged between 20 and 70 on that doctor's list giving them an appointment at a stay-well clinic.

As a result, between 1 October 1968 and 31 December 1971 2,948 women aged between 20 and 39 (out of a possible 5,121, based on 1966 census figures) and 2,520 women aged between 40 and 59 (out of a possible 7,351, based on 1966 census figures) were screened by the Ayre's technique by their doctors or at stay-well clinics. No invasive epidermoid carcinoma of the cervix was found among the younger age group but 12 of them were found to have intra-epethelial cervical carcinoma. The corresponding figures for the older age group were 11 and 12. Thus the harvest of cancer was greater from the smaller, older group than from the larger, younger group.

We wished to discover how screening of women aged between 20 and 70 and the treatment of any cervical cancers found would affect the mortality among our small but fairly static population. A survey of cancer registrations during 1949-68 showed that in that 20-year period there were 108 cases of invasive epidermoid carcinoma of the cervix and that in 56 the patient had died. By comparing the number of cases found with the number of patients killed by their cancer in each quinquennial age group it was shown that there is a greater chance of reducing mortality from cancer of the cervix if the older group of women is examined rather than the younger.

Because of these findings we shall aim our next essays in persuasion particularly at women aged between 40 and 60, but so unresponsive are the majority of women that the expansion of the campaign to the younger women was far-seeing. What needs to be done is to change the attitude of women to the test. We have found the younger women more ready to come for a smear test than their elders, and the opportunity offered by a final postnatal examination to suggest a smear test should be taken.

Women attending our stay-well clinics are warned to report unusual vaginal bleeding. A woman who had a negative smear in February 1971 reported postmenopausal bleeding in November. The Ayre's test was then positive. She had an endocervical cancer, and the gynaecologist remarked that in taking specimens for biopsy he seemed to go through a "crust" of normal tissue. In another case a smear test was negative but curettage of the canal showed epidermoid carcinoma. Endocervical cancers (and adenocarcinoma of the body of the uterus) are sufficiently common to make the warning about unusual bleeding imperative.—I am, etc.,

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1 Davies, S. W., and Kelly, R. M., *British Medical Journal*, 1971, 4, 525.
2 McInroy, R. A., *British Medical Journal*, 1966, 1, 1472.

Ileocolitis after Exchange Transfusions

SIR,—In Liverpool in the last year we have been concerned about a number of cases of ileocolitis after exchange transfusions in newborn infants. I have now found a hazard which may or may not be relevant to this problem. In my maternity unit I use the Grant heating chamber, which was passed by the Department of Health as a safe apparatus. The machine incorporates two thermostats so that if the heat of the water rises to 37°C a red warning light appears and a second thermostat takes over so that the heat does not rise higher than 39°C. This would seem to be "fool proof" so long as the lamp in the red light is working.

I have found, however, that my nursing staff have in the past filled the chamber with hot water from either an electric kettle or the tap. The wiring is such that in these circumstances the warning red light does not go on. Some of these heating chambers have a clock temperature gauge but this is not present in my model. The maternity unit in Liverpool other than my own that has had cases of ileocolitis uses the Bristol warming machine. When boiling water was poured into it by me the red warning light did not go on.

There are obviously many hazards that can result from over-heating the donor blood—haemolysis of cells, possibly release of nitrogen gas which, if present in small bubbles, could be missed by the operator, quite apart from the possibility of release of toxic substances from tubing heated to a high temperature. Professor P. P. Rickham and I will be publishing a short paper in due course on our cases of ileocolitis.

The above hazard is, I think, of such importance that I felt there should be no delay in directing the attention of paediatricians to the risk. I have spoken to the makers of the Grant warming machine and they will be able to rewire the apparatus to exclude this possible complication. In the meantime a large notice has been put on my machine stating that only cold water must be used.—I am, etc.,

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Care of the Mentally Handicapped

SIR,—I am surprised that there has been so little reaction to the letters from Mrs. Jean Patey (2 October, p. 50) and Dr. D. A. Spencer (30 October, p. 301). The importance of the letters lies in the fact that they question all the facile assumptions that underlie the present planning of services for the mentally handicapped by the Department of Health and Social Security, recently published as a White Paper[1] entitled *Better Services for the Mentally Handicapped* (3 July, p. 4). Both correspondents make a number of points of fundamental importance requiring further consideration. They are as follows:

"Better Cared for at Home"

"The parents of subnormal children have been indoctrinated with the idea that they are better cared for at home," simply because any improvement in hospital conditions would cost a considerable amount of money. The advocates of the Scandinavian services who are so critical of the present care that hospitals give to the handicapped in this country omit to mention that the Scandinavians are pouring money into their services for the handicapped, and yet according to Dr. D. C. Jones (13 November, p. 429) they still have not succeeded in solving all the problems of providing an adequately satisfactory service. At the same time the hospitals are forced to attempt the provision of treatment and care under deplorable material conditions and lack of finance. To my knowledge there has been no attempt at comparing the quality of community and hospital care under conditions which are comparable, that is, when the cost a head is the same. At present, in the London Metropolitan area at least, the cost of keeping a handicapped person in the community is roughly double that of keeping him in hospital.

Deterioration on Discharge

That the patients who are settled, clean, and happy, and giving little trouble in a hospital setting, do break down if they are not given the skilled nursing care which they have in hospital. This aspect is completely ignored when an attempt is made to assess hospital patients for suitability to transfer to community care. The claims that up to 50% of patients who are now cared for in hospitals are capable of living in the community, either with their families or in hostels, are generally made by people who have little practical experience or knowledge in the field of mental handicap. The claims that hostels can take the same type of patients as hospitals has never been substantiated, and it is the experience of most clinicians that hostel authorities refuse to consider any patients who present any difficulties in the care they require or any behaviour deviations.

Needs of the Adult

The need to understand the social requirements of the adult. Most of the plans of services for the handicapped are based upon the emotional and social needs of young children and show a basic lack of understanding of adult social needs. Adults need to live in communities which give an opportunity for social interaction and, above all, allow individuals to function as participating members of the social group. These needs can only be satisfied if the individual lives in a group composed of his intellectual peers. If the individual's intellectual capacity happens to be disproportionately high or low, identification with the social group becomes impossible. It is this aspect of the hospital—being a supportive community as well as a place of treatment, care, and training—that is so ignored at present. Our predecessors, whom it is fashionable to decry for lacking in humanity and perception, were in fact only too well aware of the social needs of people in their charge. This incidentally is one of the reasons why many present hospitals all began as "colonies."

It is unfortunate therefore, that the Department, in spite of its acknowledgement that further research and investigation is needed, is committed to community care, to the exclusion of improvement in the quality of care in the hospitals to the point of stopping any building in large hospitals beyond one ward. The practical result of such policy is twofold. The first is that patients will be condemned to live in unacceptable conditions of overcrowding in large wards until such time as the community services are built up, and this may take many years. Secondly, the running down of hospital services will have a very adverse effect on morale and recruitment,