proper in their use. The negotiators' claim to speak for hospital consultants when insisting on a standard sessional contract with little or no supplement for those with a total commitment to the N.H.S. should be tested by referendum. A leading article (14 December, p. 616) suggested that the results of the B.M.A. questionnaire (7 December, p. 608) supported the profession's negotiators. This is not so. The most popular contract preference was for the 10-session "defined contract" (45·9%), but consultants who gave that as their preference may well have been voting for a basic 10-session contract with a suitable defined and remunerated whole-time commitment.

We trust a referendum will be held when the contract options are more precisely known and believe that many consultants will be happy to accept a properly priced full-time contract. We are unhappy at the thought of a standard sessional contract without a complete commitment allowance, as some of us could be forced to seek private work. If all consultants were allowed to practise in the private sector this might influence the Review Body to price the N.H.S. sessional work accordingly. Such pressure would be most distasteful and manifestly unfair to those in areas or positions with little or no opportunity for private practice.—We are, etc.,

D. W. Bethune
B. B. Milstein
C. D. R. Flower
D. W. Evans
J. M. Collis
P. G. I. Stovin
S. W. B. Newsom
J. E. Stark
R. D. Latimer
L. C. Lum
E. M. Cheffins

Regional Cardio-Thoracic Centre,
Papworth Hospital,
near Cambridge

Sir,—Mr. J. P. Lythgoe (28 December, p. 772) expresses admirably the fears of many consultants about a 10-session contract. I should like to add a comment.

Nobody, not even the Review Body, really believes that a part-time consultant's responsibilities are limited to 31½ hours; this is a convenient fiction which operates wholly to the consultant's advantage. By its very lack of precision the existing open-ended contract gives us an incomparable measure of clinical freedom and independence. It seems incredible that our negotiators can contemplate surrendering this position for the sake of a questionable short-term financial gain.

A closed, 10-session contract has disquieting implications for consultants, especially surgeons, now doing private practice. At present consultants do N.H.S. work outside their official sessions and private work within them as the occasion demands—an arrangement that benefits both branches. This flexibility stems from the "notional" nature of our present contract. But the proposed new contract, with its emphasis on "payment for work done," implies a much closer connexion between remuneration and time spent on the job. Claiming extra money for out-of-hours work means that one will be expected to devote one's regular sessions to N.H.S. work. And 10 sessions pledged to the N.H.S. will leave little time for private practice. Theatre staffs, for example, are unenthusiastic about non-urgent surgery at weekends.

Consultants can choose between contracts whereby they work either to the spirit or to the letter. But they cannot have it both ways. If they choose to work to the letter, then the Government for their part will hold them to the letter. In my view the pursuit of a closed contract is a misguided exercise which is not in the long-term interest of consultants.—I am, etc.,

Hubert de Castella

Burton General Hospital,
Burton upon Trent

Sir,—We are in full agreement with the letter from Dr. W. Fine and his colleagues at Newsham General Hospital (4 January, p. 41).—We are, etc.,

Austin T. Carty
N. Coulshed
E. J. Epstein
Alexander Harley
N. Jones
Percy Jones
C. S. McKendrick
Eric Walker
D. C. Watson

Sefton General Hospital,
Liverpool

Sir,—Amid all the indignation and controversy regarding the Government's contract, which most of us received over the Christmas holiday, little has been said either privately or publicly about the fact that we are being offered a package without a price.

Surely no other body of workers, either manual or professional, in Britain would be foolish enough even to consider a contract affecting their way of life, and indeed the future of their work, job, or profession, before any mention had been made about the financial terms applicable to it.

May I suggest that without further delay the Minister be told that we are not prepared even to consider her package until it is priced?—I am, etc.,

David Harland

Luton and Dunstable Hospital,
Luton, Beds

Sir,—With regard to the present negotiations concerning a new consultant contract, let our negotiators not forget the unnecessary travel expenses incurred by the full-time salaried consultants whom the Government appear to be so anxious to encourage. These consultants, senior hospital staff, and registrars provide consultant services to hospitals, clinics, and family doctor consultations outside the areas of the teaching or district hospitals. The community hospitals will also be looking for these services and support in the near future.

Just as the Government will be expected to provide full equipment and facilities, the presence of a consultant at a consultant clinic will also be the responsibility of the N.H.S. This can be ensured only by transporting him to the clinic from his teaching or district base hospital by means of a hospital transport service such as is already organized for transfer of patients. This would be economical both to the Government and to the consultants. The Government would make tremendous savings in travelling expenses now paid to consultants by making car-hire arrangements on a fleet contract basis and the consultants would no longer have to buy cars at ever-increasing inflationary prices in order to fulfil their commitments and at the same time subsidize the N.H.S. out of their salaried contracts. Fleet cars would be available at base hospitals and the consultant would require only a driving licence and a time sheet to clock the car in and out. Those consultants who wish to retain the present arrangements for travel expenses should be allowed to do so.

In this part of the United Kingdom, and the same will apply in other parts, 50 miles (80 km) each way to a clinic is not uncommon, while 80 miles (130 km) is not unknown. We wish to stress that the present iniquitous arrangement for travel expenses must be revised in the new consultant contract.—We are, etc.,

P. P. Mulhall
G. O. Thomas
L. Dolny
M. Bhakta
Ehsanullah
S. Keidan

Bronllys Hospital,
Brecon

Sir,—I never imagined that I would live to see our profession prepared to sacrifice the well-being of patients as a form of barter for more money, because this seems to be in essence what it is all about. I cannot understand, either, this furore about a whole-time salaried service interfering with our independence and code of ethics.

I do not quarrel with the concept of a just salary, but I am far from happy about the way certain consultants are pressing their claims. The profession is surely hypocritical when it can protest about the harm that a laundry workers' strike will inflict upon patients and then be prepared to impose sanctions, deliberately inflicting hardship on folk who have genuine disabilities which interfere with a normal life.

I believe that there are many of the medical profession who feel disturbed by this action and who feel as I do that we have now finally lost the respect of the public and that our ideals have been sadly tarnished for ever.—I am, etc.,

W. J. Abel

Norwich

Sir,—The stand the consultants are taking is the first major resistance to complete left-wing domination in this country.

This faction is prepared to sacrifice our thrift, diligence, and democracy to achieve its ends—1975 is probably the last chance for the rest of us to demonstrate that they are in a small minority.—I am, etc.,

A. P. Bray

London W.1

Private Beds in N.H.S. Hospitals

Sir,—May I suggest that it would be in the interests of the Department of Health and Social Security, of Mrs. Castle, and of the people of this country that all hospital doctors should, for the most part, work in N.H.S. hospitals? The threat to phase out—abolish—private practice in national hospitals will defeat this end. It would be a tragic waste if anything were done to encourage the setting up of a parallel private hospital service and an increase in the number of doctors wishing to emigrate.

Mrs. Castle and her party might consider that 30 years ago Aneurin Bevan was wise in

taking a decision as uncongenial to him as it is to her. To quote from Michael Foot's *Aneurin Bevan, 1945-1960*,[1] "He agreed that specialists would encourage the establishment paying patients in hospitals. The risk was obvious, but the representatives of the Royal Colleges of Physicians and Surgeons had told him that without this concession some specialist would encourage the establishment of private nursing homes. To get the specialists into the hospitals and to keep them there as regularly as possible was crucial to the whole enterprise. He bowed to the necessity before he had ever opened consultations with the B.M.A."

The minority of patients who would like to pay for privacy and a specialist of their choice in *their* hospitals, which as taxpayers they provide and maintain, have, I submit, the right to demand that this should not be denied them. When Mrs. Castle had a bed in the private wing of University College Hospital she, as a Minister of the Crown, simply had to have a room of her own with a telephone so that she could continue to conduct essential business. To call this queue-jumping is to ignore the fact that the time and services of some people are far more important to the community than the time and services of most of us.

No one would want the Prime Minister and his ministerial colleagues, and their counterparts in the opposition, to add their names to a long waiting list or to be obliged to go into nursing homes likely to be less well equipped than a modern N.H.S. hospital. When it comes to general practitioner treatment I expect our governors have to have private practitioners. When Mr. Harold Wilson had his recent indisposition after a visit to Paris no one would have expected him to sit in the waiting-room of a health centre or to be told that his doctor could not visit him for two or three days. And if he needed hospital treatment he would, for security reasons alone, have had to have a private room, preferably in a well-equipped modern hospital.

And then there are many other persons whose time and services are more valuable to the community than those of the ordinary man in the street. They need privacy to conduct their business as leaders of industry and managers of public enterprises. Though as a medical man I might expect extra consideration from my old teaching hospital if ill, I preferred to subscribe for years to a medical provident scheme. This enabled me to pay the surgeon of my choice for severe operations on my wife in the private wing of his hospital. I think it is unwise—politically unwise—of Mrs. Castle to deny this to others who take this prudent precaution—deny to them the facilities she took advantage of when in need of expert care herself. To quote from your excellent leading article (4 January, p. 4), "Is she really so indifferent to the welfare of British medicine?"

May I end, Sir, by suggesting that it is time we stopped describing a *medical* service as a *health* service. And let us at the same time restore to some of its old dignity what was a fine health service, called the Public Health Service.—I am, etc.,

HUGH CLEGG

London N.W.3

[1] Foot, M., *Aneurin Bevan, 1945-60*. London, Davis-Poynter, 1973.

G.P.s and the Crisis

SIR,—Surely now, if ever, the moment of truth for the medical profession is arrived, and I for one wish to express my support for our consultant colleagues in the action they are taking. I much regret that such action has been left to a small and perhaps vulnerable section of the profession and, while firmly supporting the B.M.A. in this matter, feel that a united front might have been more appropriate. It is scarcely possible to doubt that the turn of general practitioners will come.

The medical profession, by and large a dedicated body of men and women with a sense of vocation, have in the majority slaved over the past 26 years to make the Health Service a success. Their reward for this effort has been repeated obstructive interference with their professional rights and a salary scale that has made them the objects of pity and incredulity by other medical professions in the free world.

As much as anything we are fighting for self-determination and the freedom to treat our patients in the way we think fit, either within the Health Service or without it. We must brook no more interference, no more meddling, no more political intrigue, and must demand that a totally non-political corporation should be set up, similar to the B.B.C., to run the service.—I am, etc.,

F. V. GRIFFITHS

London S.W.10

SIR,—The hospital consultants are showing action; so must we general practitioners. There is only one way: resign. This does not mean go on strike. Of course we shall still attend to all patients, but a fee will be charged. Prescriptions will not be written on EC10s; therefore the patient will have to pay for the prescription at the chemist. It will take only a week or two for the public to inform the Government of their displeasure. We shall then receive our just increase in income to maintain our standard of living. We must not wait until April; it will then be too late.

The B.M.A. must send to all general practitioners a referendum asking if we are willing to resign, with no other alternative. I am sure that the positive response will be great.—I am, etc.,

BARRIE HANSTEAD

Upminster, Essex

Well-woman Clinics

SIR,—It is distressing that the cost effectiveness and priorities of patient care need to be evaluated as a medical compromise in our underfunded Health Service. But if this is to be we must support the challenge of Mr. R. T. Burkitt (7 December, p. 588) in questioning the value of well-woman clinics for young patients. However, not wishing to appear to be the Luddites of preventive medicine, we would urge the creation of menopause clinics within the N.H.S. as an alternative. Apart from the growing evidence that the climacteric is an insidious deficiency state requiring oestrogen therapy in order to protect the skeleton and general well-being, this selection of the female population offers a greater source of early and treatable disease.

The first 200 patients attending the two menopause clinics in our hospitals have yielded four positive cervical smears (two carcinoma in situ), three breast lumps (one early carcinoma), and one each of endometrial carcinoma, melanoma, diabetes mellitus, hypertension, and hypercalcaemia.

The postmenopausal population is clearly a high-risk group. It is also our belief that women can more readily be lured into well-woman clinics by their distressing vasomotor symptoms, their diminished sexual responsiveness, and their hopes, however misplaced, of "feminine forever" than by a primary concern about the presence of early disease.—We are, etc.,

JOHN STUDD
DAVID ORAM
SUDIP CHAKRAVARTI

Department of Obstetrics and Gynaecology, King's College Hospital, London S.E.5

BEN MOORE

Birmingham and Midland Hospital for Women, Birmingham

Haemophilus influenzae in the Elderly

SIR,—A leading article (1 June, p. 462) recently pointed to the increase in the prevalence of infections with *Haemophilus influenzae* in the past three or four decades. Dr. Susannah J. Eykyn and others in the same issue (p. 463) described an apparently new trend towards meningitic infection with this organism in adults, but in your articles and in the available literature it is emphasized that the main importance of *H. influenzae* is in infections of infancy and childhood. In my experience, however, the organism is already a significant cause of morbidity, and occasionally mortality, in the elderly population.

In a consecutive series of 42 patients admitted to a geriatric assessment unit nasal swabs, throat swabs, and specimens of sputum were cultured. *H. influenzae* was identified from the sputum as the causative organism from four patients, all male, who had clinical evidence of chest infection and from the sputum of two women who were asymptomatic. Two of the men and one of the women had *H. influenzae* in their sputum on admission to hospital; both the men died of bronchopneumonia, in spite of treatment with apparently appropriate antibiotics, within a month of admission. The rest of the positive sputum cultures presumably resulted from cross-infection in the hospital wards within one week of admission of the patients, who were initially free from chest infection.

In all six patients *H. influenzae* was shown in the laboratory to be sensitive to ampicillin, tetracycline, and co-trimoxazole. Resistance to cephaloridine was noted in several specimens from one of the patients who died. Though resistance to other drugs was not encountered in laboratory tests, *H. influenzae* proved to be much more difficult to eradicate clinically than its theoretical sensitivity suggested. The prognosis was clearly worst for those patients infected with the organism before admission, but the introduction of *H. influenzae* into a geriatric unit provided a significant and continuing morbidity among