

Oesophagoscopy should be performed to exclude carcinoma; the ease with which the instrument passes the sphincter belies the radiological appearances and indirectly supports the diagnosis.

Treatment is still controversial. The tone of the cardiac sphincter may be decreased by mechanical rupture of its fibres (forceful dilatation) or cardiomyotomy (Heller's operation). Both procedures may give rise to after-effects, both have partisan supporters, and satisfactory controlled trials are lacking. In the United Kingdom the emphasis has been almost exclusively on cardiomyotomy in recent years, but adequate careful dilatation under radiological control may still give good results in up to 77% of patients, even after more than three years.<sup>16 17</sup> Either form of treatment should be performed early, before the oesophagus becomes permanently enlarged, and even then lung disease may not be prevented.

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## Private Practice in Teaching Hospitals

Two subjects of current interest in the U.S.A. are methods of funding medical schools and, as a linked topic, how the academic clinician might allocate his time. The alternatives were recently discussed by three eminent American administrators.<sup>1</sup> The choices lie between the strict full-time system, where the doctor is a salaried employee of the institution in which he works; geographical full-time appointments that allow the practitioner to supplement his income from limited private practice, performed within the confines of the employing institution; and group partnership private practice in which individuals put their fees into a common pool from which they each draw a salary up to a previously agreed ceiling, the residue then going to the medical school. This last scheme enables the rich departments in the medical faculty to support those where the private practice income is smaller or absent. Though the differences in the finance of health care on the other side of the Atlantic invalidate direct comparisons with this country, there were a number of points considered in the symposium that are relevant to the British situation.

Perhaps the most interesting factual findings come from a survey<sup>2</sup> of the activities of American academic clinicians. It seems that non-surgeons who are strictly full-time spend

considerably fewer hours attending patients than their geographical full-time colleagues and have very many fewer patients to care for. Indeed their clinical practice seems so restricted that one wonders whether such a limited exposure to clinical medicine allows them to remain competent to practise and teach. On the other hand, as one might imagine, strict full-timers spend much more of their time doing research and (as will be known<sup>3</sup> to followers of the British scene) in travelling. Geographical full-time workers evidently do their share of teaching and are considerably more successful, for reasons unspecified, in obtaining research grants. They also draw a larger salary—so it is hardly surprising that more geographical full-timers were satisfied with their jobs than the strict full-timers, surgeons or non-surgeons.

In Britain, the clinical staff of university hospitals is made up of N.H.S. employees, who may be whole or part-time, and those whose salary is paid by the university. The whole-time N.H.S. consultant may be just as academic as the professorial head of a clinical department, while some of those holding university posts may do as much clinical work as their N.H.S. colleagues. It is dangerous to generalize on the work of the staff of the British teaching hospitals, as patterns vary across the country, but in some institutions the Flexnerian view of the professorial department still prevails. Staff, money, and space in the hospital and medical school, the argument runs, should go to the professorial unit since there they will be used most efficiently. This results in gross imbalance between university departments and N.H.S. groups. In other teaching hospitals there is a happy symbiosis between the university and N.H.S. staff, where each has a service commitment coupled to a clinical and research interest in one or more areas. The professorial unit has the prime responsibility for the organization of undergraduate and in some instances postgraduate teaching. In this system there is little difference between the activities of university and Health Service employees, provided the latter work on a full-time contract. There is, however, still considerable variation in the role of the part-timer. The doctor who has a busy, private practice and at the same time carries out worthwhile research is still a rarity. Where there is a choice, cash usually wins.

There is a trend among physicians in teaching hospitals towards acceptance of a full-time contract, mainly owing to their having developed in the course of training a visceral urge to continue in clinical investigation. It is also partly a reflection of the relatively poor monetary reward that accrues to all but a few and of the widely held, but possibly erroneous, feeling that a great deal of time spent in private practice is devoted to caring for the trivial. Of the other clinical branches of the profession, academic or full-time appointments in surgery and gynaecology are unpopular because of the very considerable financial rewards available from private practice. Furthermore, there are still some financial sanctions imposed on those working for the university and paid out of university funds. Increases in doctors' salaries come to university staff a month or two after they have reached their health service confrères—no insignificant penalty when interest rates are running at approximately 15%. University employees are still not given the very large removal allowances available to health service staff, and those in training are not eligible for the extra duty allowances payable to N.H.S. training grades. If the universities wish to compete in the market for the best clinical brains then they must be prepared to pay their employees the same as the N.H.S.

There are other anomalies: the professor with an honorary N.H.S. appointment may see private patients and charge them

provided he does not put the fees to personal use but has them held in departmental funds to support the academic needs of his department. His full-time N.H.S. colleague, doing exactly the same work, is not allowed to send a bill. The usual convention is to solicit a gift for an appropriate research fund. This ruling was doubtless made to maintain the distinction between the full and part-timer.

Since private practice forms a very limited part of the British system the conclusions of the American study are not strictly relevant here; and any comment on the pattern of private practice must necessarily be considered as a generalization. However, it might be argued that limited private practice with perhaps a ceiling on the amount of money that could be kept by the individual would benefit the institution in which he worked. In these days of financial stringency, any extra income for academic use would be welcomed to eke out the strained budgets of the medical schools. The widely accepted advantages of private practice, such as the bringing together of hospital doctor and general practitioner, or the exposure of the doctor to testing clinical problems that need to be solved in a different context from that in which he is usually working, could serve the additional purpose of enriching the clinical experience of the school. But the idea of letting all teaching hospital consultants spend some time doing private practice in their own hospitals with some of the income going to them and some to the medical school will doubtless be criticised on political grounds and also by those freelance practitioners who would feel that such a scheme might constitute a threat to their livelihood. Nevertheless, it is a topic that merits debate, and possibly action.

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<sup>3</sup> Hawkins, C. F., *Lancet*, 1972, 1, 590.

## Stopping the Pill

Perhaps 14 million women the world over use contraceptive steroid pills. Many of them must now be in their 40s and some into their 50s. The problem for them and their doctors is to decide when—if at all—they should stop taking the pill.

Steroid oral contraception is now such a commonplace of medical life that it is hard to remember that it began in Puerto Rico only in 1956 and that the first results were published<sup>1</sup> in 1958, only 16 years ago. The revolution in thought and the amount of books and papers published since then are almost unbelievable. It is not surprising that such a profound change was received so cautiously. There were originally anxieties about the possible long-term effects on the endocrine system and on fertility. Quite early the association of oral contraception with thromboembolism was recognized; and there were worries about liver dysfunction, carcinoma of the breast, carcinoma of the endometrium, carcinoma of the cervix, diabetes, hypertension, and many other rarer diseases. The dust is settling a little after these earlier controversies, and the articles written in the fifties and sixties often showed more of their writers' attitudes to sexual mores than of interpretation of the evidence to hand, though these attitudes were rarely overtly expressed. But the matter is now decided by the women themselves. The medical function is the assessment of risks in individuals and the attempt to prevent the prescription of

oral contraceptives for those who might be endangered by them.

The overall mortality rate per year for women aged 35 to 44 on combined oestrogen progestogen pills has been estimated<sup>2</sup> as 34 per million users, nearly three times as high as the death rate in those aged 20 to 34. There seems to be no certain evidence that these steroids are especially associated with cancer of the breast or of the endometrium. Cervical cytological appearances may change while a woman is taking the combined pill, but a recent investigation in Puerto Rico in almost 5,000 patients and 5,000 controls showed that these changes are no different in the two groups.<sup>4</sup> The many papers on liver dysfunction suggest that the alterations rarely rise to a level of clinical significance. Neither hypertension nor diabetes are very common and they can be watched for. There are, then, dangers in taking oral contraceptives, and they may well be increased as the woman gets older, but the recent report from the Royal College of General Practitioners,<sup>5</sup> based on observations on 46,000 women, found no side effects that had not been reported in earlier studies. Both mortality and morbidity can now be estimated reasonably accurately. On the opposite side of the equation must be placed any risks of pregnancy in this older age group, estimated at 576 deaths per million births in the ages 35 to 44 in England and Wales in 1966,<sup>3</sup> and the relief from anxieties about pregnancy and the feeling of well-being experienced by so many women while they are taking sex steroids.

Provided that the usual precautions are taken before prescribing oral contraception in the older age groups, the risks seem acceptable, though opinions on this will differ. As with oral contraception in younger women, it is probably the women themselves who will decide, and many of them will want to carry on with their pills. In the face of the current evidence doctors cannot deny them on medical grounds.

There still remains the decision on when contraception should stop. The normal menopause has a modal and median age of 50.1 years in Britain.<sup>6</sup> In a few women it may be delayed till 55 or beyond. When women are menstruating at the age of 53 or more many clinicians believe that they should be examined under anaesthesia and have a curettage to be sure that there are no local abnormalities, and the process may need to be repeated annually. The chances of pregnancy after the age of 50 must be very small and are nearly non-existent. Contraception can, therefore, probably cease at this age, but possibly not before. It used to be recommended that some other form of contraception of the barrier kind should be used whilst the effects of stopping oral contraception were observed. This is probably unnecessary if the oral contraception is carried over into the sixth decade. However some women do ovulate at these later ages, so a careful watch should be kept for the rare and unexpected pregnancy so that termination may be offered. Until there is more experience it is obviously essential to monitor these older women on oral contraception with even more care than is given to the younger ones. They should have at least a clinical examination with urine testing, cervical smears, and blood pressure recording every six months, and there might sometimes be indications for phlebography and tests for glucose tolerance and liver function.

There is now an increasing interest in hormone replacement therapy continued indefinitely after the menopause.<sup>7</sup> Oestrogen administered at that time is said to reduce the incidence of coronary thrombosis and of osteoporosis, which is probably responsible for much of the discomfort experienced by some older women. Such therapy must begin before the endogenous oestrogen supply fails and before decalcification of the bones