G.M.S. Committee (*Supplement*, 5 December, p. 201). I hope it is not because the G.M.S. Committee is represented in the Working Party. It would be a pity if its comments were regarded as holy writ.

In particular, its remarks about the employment of locums deserve close study, as in my opinion they are based on false premises. Briefly, the Working Party states that a general practitioner's net pay is for the continuous care of his patients, 365 days a year, and that "reimbursement of locum fees constitutes an unintentional overpayment to general practitioners as a whole, and that they should therefore be excluded from the Central Pool."

What is the authority for this statement? Who has said, in effect, that the £2,765 net income is payment for *continuous* care? Certainly not the Review Body, who have so far awarded cost-of-living increases only. The Royal Commission (1957–60) compared doctors' remuneration with that of other professions; how could they say that a general practitioner's net income was for 24-hour service, when no other person, professional or otherwise, has such a contract? They could only assume that a practitioner would work *comparable* hours for such an income, and that payment to locums, assistants, and *deputies* would be recovered from the expenses pool.

This is a fundamental issue which has been avoided for too long. The Review Body must be asked for its ruling as a matter of urgency, especially as the G.M.S. Committee is at last encouraging us to declare *all* our expenses.—I am, etc.,

Alexandria, Dunbartonshire. W. JEFFREY C. SCOTT.

Value of Cottage Hospitals

SIR,—General practitioners are unhappy. Hospitals are desperate for junior residents. The hospital building plan, if and when completed, will remedy neither of these. A healthy happy society cannot be manufactured. It must grow spontaneously from small units. Direction should be used mainly to help natural growth. I have seen such a natural growth in an extremely small way develop into a small organism of value, still serving usefully in the N.H.S. If similar such units could be started all over the country they would go a long way to relieve the troubles of the N.H.S.

After the first world war a surgeon backed by local finance started a cottage hospital—one cottage, one nurse, two patient beds, one portable operating table. It served the area of three country general practitioners. It is still a very small hospital, only 15 beds—admittedly barely economic in bed occupancy—but it serves all the general practitioners in a much enlarged and growing area. The general practitioners are happy, having their own beds and responsibility. The consulting staff, general surgeon, E.N.T. surgeon, gynaecologist, orthopaedic surgeon, general physician, have regular out-patient consulting sessions, and operating sessions. In addition to doctors' letters, general practitioners can and do pop in for ten minutes' personal consultation, for which their patient is taken out of turn, with the full approval of the others waiting, because they see and know of the personal interest.

In addition to these facilities there is a very busy physiotherapy clinic, a daily messenger from the pathological laboratories of the base hospital, and *x*-ray facilities whenever a radiographer can be found. Such a hospital with 30–60 beds can arrange a turnover keeping a high rate of bed occupancy, and is considered financially viable. Ten such in a hospital group would provide about 500 beds which would require no resident junior staff—surely a great economy. Small local hospitals find it less difficult to recruit locally part-time married nurses. From the patients' point of view they are very much liked. From the consultants' point of view they do not conflict with his specialist hospital, but feed it.

When such a cottage hospital, whether rural or urban, has become established it should be possible also to base the public health services on it, as the local medical centre—and we have a complete health centre, grown and viable, not manufactured or full of friction. Would it be possible to organize an inquiry as to the opinions of all Divisions on such a nation-wide scheme?

It is said that general practitioners are individualists, and can never agree. Perhaps there has never been a scheme to which general practitioners could agree. Perhaps they could agree to this, and carry their consultant colleagues.—I am, etc.,

H. D. FORBES FRASER.

Eastbourne, Sussex.

Appointment Systems in General Practice

SIR,—I note with dismay the present habit of equating appointment systems in general practice with increased efficiency. I think I am in a position to judge the relative advantages of "set hours" surgeries and appointments, as we make use of both in this practice. Antenatal and post-natal examinations, infant immunization, minor operations, and insurance examinations are done by appointment.

In a small clinic the rate of "defaulting" is about one in six. Each patient who does not turn up wastes fifteen minutes of a doctor's twelve-hour day, mainly spent working against time.

With set surgery hours patients' waiting time and hardship can be reduced in several ways:

(1) By having long enough hours of attendance.

(2) By allowing patients to come to the waiting-room as long as they wish before surgery starts. By making this waiting-room as comfortable as possible. By beginning surgery, whenever possible, well before the advertised time—this especially applies to morning surgery.

(3) By arranging appointment times for procedures likely to be lengthy, as mentioned above.

Any idle minutes during surgery can be spent in dealing with correspondence—otherwise a late-night task.

Two faults seem inherent in the appointments system:

(1) Patients other than emergencies must often wait for days for an appointment. Who is to decide what is and what is not an emergency? Perhaps those who shout loudest will be seen first.

(2) Patients will generally be seen at intervals of either ten or fifteen minutes. A consultation may take either half a minute or an hour. It seems to me that much time must be wasted.

Finally, may I say how much I regret the passing of the old system of hospital consultations at set hours; and I know my patients do, too. A consultant used to be in attendance in hospital out-patients on a given day, between certain hours, and remained until he had seen all patients referred on that day with a letter from their doctor. Now, many patients have to wait not hours but weeks to be seen. As a patient, I should prefer to wait hours.—I am, etc.,

Highbridge, Somerset. JOHN LITTLE.

Conditions for Laboratory Technicians

SIR,—In the *Supplement* (5 December, p. 203) reference is made to two matters concerning the employment of medical laboratory technicians. One is the question of increment credit for technicians who leave and re-enter the hospital service.

In case the reference is misunderstood, may I point out that it is within the authority of the Minister to grant such credit, and that is not infrequently given after reference to the joint secretaries of the Whitley Committee. What we are now seeking is reference to the possibility in a Whitley circular in order that employing authorities do not assume that entry can only be at the minimum point whatever the circumstances.

The other point is the difficult question of emergency duties. For the Staff Side of the Whitley Committee may I say that we are utterly opposed to obligatory emergency work? We are satisfied that technicians are willing to do the work voluntarily if they are able to do so. There are some who cannot, and to make the duty obligatory would only drive them out of the Service and increase the shortage of laboratory staff.

The Staff Side is equally opposed to a shift system, which would inevitably become obligatory with the same effect. We are satisfied that with good management the emergency-duty system with built-in alternatives will work satisfactorily, and that any alternative system will in any case need to be negotiated through the Whitley Committee.—I am, etc.,

JOHN DUTTON,
Staff Side Secretary,
Whitley Councils for the Health Services (Great Britain),
Professional and Technical Council B.

London W.1.

Prescription Charges

SIR,—I have never understood the logic of the argument of those who imply that a prescription charge is immoral because some have to pay more than others. Food is more important than drugs; therefore it would be surely more just if the Government supplied free food.

Could we live in this climate without clothes? If not, it must be the duty of the authorities to see that these are free too—wouldn't the ladies be pleased with the latest Government models! Is it not time that the profession dried its crocodile tears and faced

the true facts of human nature and the elementary first steps in economics.

£24 million is still a tidy sum to dissipate for political reasons, more particularly when money cannot be found for adequate remuneration within the profession.—I am, etc.,

Newport Pagnell, Bucks. A. A. CLAY.

Eliminating Cervical Cancer

SIR,—I was interested to read Dr. G. Ramage's suggestion from the Association of County Medical Officers (26 December, p. 1659) that the members of his association be made the sole channel through which cervical screening should be carried out.

Of course the public health services have great experience in the carrying out of population screening, an experience which will be of the greatest value. But I feel that it would be a retrograde step to perpetuate once more the totally artificial distinction between "preventive" and "curative" medicine. It is difficult enough to persuade a total population to attend for such impersonal examinations as chest radiography and urine testing, and to get maximum screening when vaginal examination is required will take more than education by health visitors.

As I wrote earlier (12 December, p. 1531), the family doctor can, if given adequate time, screen a very large number of his patients with little alteration in his normal working habits. These patients, being in many cases "symptomatic," are likely to produce a higher pick-up rate than the average population, and they will certainly include a considerable number of those who would not attend publicly organized sessions.

The absence of predetermined pattern which makes the association wish to withdraw the right to submit specimens is quite irrelevant. A smear is of value whether it forms part of a public health pattern or not, and positives occur even when a negative smear has been obtained in the recent past. I would submit that it is much too early to attempt to impose a doctrinal pattern, and that all branches of the health service will have to work together without thought of vested interest if the service to the public is to be efficient.—I am, etc.,

Bletchley, Bucks. GEOFFREY RIVETT.

SIR,—Dr. R. A. McInroy (19 December, p. 1591) asks the truth about the delay in developing exfoliative cervical cytology. The truth is that all diagnostic hospital pathology is seriously neglected by everyone not directly concerned in it. Ministerial policy is to accept and devise schemes which will stretch inadequate laboratory facilities still further. The outstanding deficiency is in trained technicians, and it is essential that we recruit and train more technicians, especially the senior technicians who will later train others.

A major industrial State, increasingly dependent on highly trained technicians, is allowing its medical services to be crippled by ignoring their existence.—I am, etc.,

Walton Hospital, Liverpool 9. H. E. VICKERS.

Management of Malignancy

SIR,—Mr. J. D. S. Flew draws welcome attention (21 November, p. 1329) to the widespread fallacy that vaginal cytology is invariably diagnostic of endometrial cancer, and that a negative "Pap" test means that the patient is safe. Nothing could be further from the truth, for, as Mr. Flew says: "At the most only 50% of cases . . . would be spotted by this method." The average is probably nearer 30%. This disease, though less publicized than cancer of the cervix, is becoming relatively much commoner, and the two conditions are now almost statistically equal in frequency.

Early diagnosis here is more vital than in most cancers, for the operative results are extremely good when the myometrium is not extensively involved. The answer is a simple one—every woman with premenopausal irregularity must be curetted, and that as soon as possible. The vaginal smear remains important, but the "cancer-Pap" should be reserved for the cervix; and here I would like to make the most vigorous protest against the "do it yourself" method. This has been advocated for rural areas in the U.S.A., and is, I understand, to be official policy here—the sets have already been manufactured in large quantity. Nothing can be more iniquitous than to give a woman a clean bill on the basis of a random self-aspiration of vaginal fluid. Some cases of pre-invasive carcinoma *may* be picked up this way, but many more will be missed, as Mr. Flew has emphasized.

Adequate cervical cytology requires proper visualization of the cervix with an illuminated perspex Cusco speculum, careful scraping of the exocervix and external os with the Ayre spatula, and aspiration of the cervical canal. Any other method is incomplete and should be discarded.—I am, etc.,

London W.1. ALBERT DAVIS.

Future Management of Infectious Diseases

SIR,—It was with the greatest interest that I read the paper "Future Management of Infectious Diseases" by Drs. A. Melvin Ramsay, R. T. D. Emond, and J. M. Alston (17 October, p. 1004). The question is an urgent one in many countries, and its present state in Sweden may be of some interest.

While the authorities in Sweden in the 1940's admitted the need for a radical reorganization of the management of infectious diseases their attitude at the time appeared to be that, rather than modernize the organization, no special facilities for infectious diseases were necessary. However, certain infectious diseases are admittedly disappearing but others are taking their place and the remoulding of society creates new epidemiological conditions. There has been an impressive development in the fields of bacteriology, and especially virology, which places new demands upon us, and there are also the problems associated with modern drugs and their proper administration.

The management of infectious diseases must accordingly be adapted to the demands of our time just like other medical disciplines. It requires buildings specially adapted to provide effective protection against infection, and specially trained hospital staff. The spread of infection in hospital can be thoroughly controlled only if these requirements are fulfilled. Another very important factor is co-operation with the health authorities and epidemiologists. The active participation of physicians trained in the management of infectious diseases may be of great value, as we have repeatedly found in Stockholm in conjunction with major epidemics of intestinal infections, hepatitis, meningitis, and last year's smallpox. We have for some time made a systematic analysis of all hospitalized cases of respiratory tract infections as a quick means of discovering which infections are current in the population, and this is a promising field for the future.

In the last two decades most of the remotely situated hospitals for infectious diseases in Sweden have been closed down. The Swedish Board of Health, however, did not shut all facilities for the care of infectious diseases, even if these were heavily reduced, but declared that provision should be made at special clinics forming part of the major general hospitals on a basis of 0.3 bed per 1,000 inhabitants. For Stockholm, with its 800,000 inhabitants, this means two clinics with a total of 240 beds, and in the suburbs two other clinics with the same number. If a larger number of beds is needed during an epidemic, other departments are evacuated on a predetermined plan.

With regard to the teaching of infectious disease every student will now have a two-month course, ending in an examination, and during this time he will do duty in the clinic. Rounds will be arranged also during the courses in internal medicine and paediatrics. Teaching in our country has thus been intensified very much more than previously. The infectious disease clinics offer an abundant demonstration material, and the students obviously appreciate this teaching, which they realize has a great practical significance. The teaching of nurses, on the other hand, is very much less satisfactory.

As regards future planning, therefore, it seems to me that we in Sweden have already reached some of the goals proposed by Dr. Ramsay and his colleagues.—I am, etc.,

JUSTUS STRÖM.

Hospital for Infectious Diseases, Stockholm, Sweden.

Complication of Peritoneal Dialysis

SIR,—Peritoneal dialysis for renal failure is now accepted as being a safe and efficient technique. In the medical wards of this hospital over 50 patients have been treated in this way during the past year and haemodialysis has rarely been necessary.

We have recently seen a complication of peritoneal dialysis which we do not think has ever been recorded.

Following a successful period of ten days' intermittent dialysis in a rather obese young woman, the connecting tube of the catheter (Baxter Laboratories Ltd.) was spigoted off, and two days later, when it was apparent that further dialysis would not be needed, the dressing was taken down as a preliminary to recovering the catheter. When this had been done it was found that the catheter itself had become disconnected and had presumably entered the peritoneal cavity. It had previously been secured with a purse-string suture and a piece of zinc-oxide plaster attached to the abdominal wall. Both the