either libido itself or the tendency to rate it as low. Did the increase in libido occur independently of any change in mood?

LOUIS APPELBY

Institute of Psychiatry,
London SE5 8AF

JULIA MONTGOMERY

Dulwich Hospital, London

- 1 Studd JWW, Collins WP, Chakravarti S, Newton JR, Oram D, Parsons A. Oestradiol and testosterone implants in the treatment of psychosexual problems in the post menopausal woman. *Br J Obstet Gynaecol* 1977;84:314-6.
- 2 Dow MGT, Hart DM, Forrest CA. Hormonal treatments of sexual unresponsiveness in post menopausal women. *Br J Obstet Gynaecol* 1983;90:361-6.
- 3 Montgomery JC, Appleby L, Brincat M, et al. Effect of oestrogen and testosterone implants on psychological disorders in the climacteric. *Lancet* 1987;i:297-9.
- 4 Gath D, Cooper P, Day A. Hysterectomy and psychiatric disorder. I: Levels of psychiatric morbidity before and after hysterectomy. *Br J Psychiatry* 1982;140:335-42.

AUTHORS' REPLY.—Drs Appleby and Montgomery have raised three questions about our conclusions on the value of testosterone in treating loss of libido in postmenopausal women whose poor libido has persisted despite adequate treatment with oral oestrogen.

Our patients were blind only to the type of implant that they were given at the initial visit. They were told that if no substantial improvement had occurred at their six week follow up they would be offered another implant. In the event, only patients who had been given the oestradiol implant alone requested another implant. As reported in the paper, comparisons were made between patients who received a single implant and those who received a double one in the first six weeks of the study and also between patients who received oestradiol alone in the first six weeks and then had testosterone added, so that a within subject comparison was possible for the single and combined implants.

We agree that the estimation of libido is complex and that a more sophisticated questionnaire might have had greater overall validity.

Finally, mood changes were assessed in the same way as libido and tiredness, using the visual analogue scale, as reported. There were no significant changes in mood in our study, thus strengthening our conclusions about the effect of the testosterone implant on libido.

JEAN HAILES
HENRY BURGER
JOY NELSON

Prince Henry's Hospital,
Melbourne,
Australia 3004

MARGARET MENELAUS

Royal Women's Hospital,
Melbourne,
Australia

General managers and consultants

SIR.—As a clinician who followed the advice of the Central Committee for Hospital Medical Services to become involved in Griffiths general management, I have listened to the profession's repeated denials of the existence of a relationship between general managers and consultant staff. I have read and heard it stated that consultants are not accountable to general managers except for any budget that they might hold. Such statements imply an ostrich like attitude to the true situation.

In practice, if consultants in this hospital wish to develop new clinical services or buy new equipment with revenue or nursing consequences they must put the request through my office. My agreement or refusal will depend on the manage-

ment priorities for the hospital and available resources. Is that not a managerial relationship?

If a consultant colleague is regularly late for a clinic or operating list or is alleged to abuse hospital staff or patients I will probably have a word with him or with a senior colleague. In the unlikely event of this not solving the problem I would pass the matter on to the district general manager, who may instruct the chief administrative medical officer to deal with it or himself call in the consultant to see him. I have not yet heard of a consultant refusing to see the district general manager or ignoring his decision. Surely, therefore, a managerial relationship is accepted by the consultants.

I have doubts about the meaning of "clinical freedom." Certainly, I have not known absolute clinical freedom since I was appointed in 1968. I have not been able to order instruments regardless of cost. There have always been some constraints to modify our clinical approach to a patient. Since becoming a unit general manager I have been instrumental in making further modification to the clinical freedom of my colleagues. A hospital drug guide and antibiotic policy have been introduced. Antibiotics have been divided into three groups to avoid duplication and unnecessary expense, and the third group can be prescribed only after consultation with the microbiologist. In my view, these policies have improved the quality of medical care while saving many thousands of pounds. Undoubtedly, one cost is a decrease in clinical freedom. Similar rationalisations have occurred with heart valves and orthopaedic prostheses, which carry considerable discounts when purchased from one supplier, though this restricts clinical freedom further.

I do not perceive that the clinicians in this hospital work in isolation from general management, and I see considerable advantages to all consultants and their patients if general managers achieve an equitable distribution of their resources. From the moment general management was introduced into the National Health Service a relationship existed between the general managers and consultants which was outside budgetary considerations, and I do not understand the long term advantage for the profession denying that this is so.

It is difficult for a consultant to realise how much administrative support is required for his firm to function, and he may not consider the consequences of his clinical decisions for other staff in the hospital. A labour intensive, high technology hospital requires management involvement at all levels. The corporate function of general management has eliminated the disadvantages of functional management, under which it may be impossible to cross the barriers between professions. The medical profession has much to gain from coming to terms with general management.

RUSSELL HOPKINS

University Hospital of Wales,
Cardiff CF4 4XW

Auditory rehabilitation: should we listen to the patient?

SIR.—The article by Mr A C John and Dr P Littlejohns (25 April, p 1063) makes interesting reading to a retired consultant who has experienced with more than one hearing aid for more than 10 years. My hearing deficiency is now moderately severe, but I first sought the advice of an ear, nose, and throat surgeon when, while teaching overseas, I began to experience difficulty in hearing questions and answers in classes. I was prescribed one National Health Service hearing aid, which I found disappointing as it helped when

I listened to one individual or to an address but not in conversation in a group. In addition, I found that the size of the postpinna element containing the microphone and battery caused discomfort and was only tolerable for two to three hours' continuous use.

I therefore approached a commercial firm, which supplied me with an aid that was similar but neater and smaller, which I found comfortable to wear for long periods and which enhanced the clarity of sound reproduction. I could not, however, understand why my appreciation of classical music with any aid was impaired until a discussion with a friend who was bemoaning the disadvantages of a recently acquired monocular loss of vision suggested that monaural supplementation of a bilateral aural defect might have a comparable effect. Accordingly, I bought an aid for the unassisted ear with dramatic further improvement.

Shortly afterwards, wholly intra-aural aids became available from commercial sources. I now have a pair of such aids, matched to the type and degree of hearing defect in each ear, which enable me to hear conversation and to listen to music, television, etc, with enjoyment, though at a marginally higher volume than those with normal hearing. In addition, I can wear these aids throughout my working day.

The conclusions of Mr John and Dr Littlejohns therefore seem to be founded on far too narrow a base. Even NHS departments may now provide hearing aids for both ears if both are defective, whereas the study by Mr John and Dr Littlejohns is based on the supply of one alone. A study of a group of patients supplied with two aids would be valuable. A further study of those using intra-aural aids, though desirable, might prove difficult as such aids can be obtained only at considerable expense from commercial sources. Nevertheless, the increasing number of hearing aid suppliers outside the NHS surely indicates a considerable demand. The NHS aid has, I understand, remained largely unchanged in design for over 20 years, in spite of electronic advances.

H H LANGSTON

Guildford GU5 9BB

FRCS (UK)?

SIR.—I would like to develop a point made by Professors Peter Richards and Thomas Sherwood (16 May, p 1285) in their comments on non-university qualifying examinations. They suggest that a single diploma from one examining body should be introduced, and they emphasise the success of the MRCP(UK) examination. I suggest that an FRCS(UK) is long overdue.

It is said publicly that all surgical fellowships are equal, but in private I have been told by my senior colleagues (consultants among them) that some fellowships are more equal than others. Having recently passed both the Edinburgh and London general surgical fellowships in the same sitting, I can honestly say that I found no difference in the standard of the examinations, despite differences in format.

It is a very expensive business attempting the fellowship, both financially and in disruption to domestic life. I know of several people who have been successful in one centre but, because of this covert pressure that certain fellowships are more prestigious, have to go through the same traumatic process at the next sitting. The fellowship one obtains should be determined by geographical considerations and not geographical prejudice.

MEL JONES

Swansea SA3 3AX