Although, fortunately, rifampicin resistant meningococcus is rare in the United Kingdom, we believe that doctors should be aware that these strains do exist.

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Other health services

SIR,—What an interesting view of different health care systems was offered by Dr Helga Rheim (9 April, p 1063). The grass is evidently greener in Edinburgh than in West Germany and, judging from her report, much greener than it was when I left the National Health Service in 1965.

For nearly 20 years I worked in various hospitals in Scotland and England, and I have revisited them from time to time since I left. There are many good things to be said about the NHS, but I remember the long waiting lists, overcrowded waiting rooms, lack of privacy in open wards, grossly overworked junior staff, too few consultants, and consultants with no incentive to show courtesy to patients or their general practitioners. I take my hat off to the many consultants I knew who were courteous, because it served only to increase their workload and their waiting lists.

For the past 23 years I have been in specialist practice in Australia, working in both public and private hospitals. My experience is limited to the smalle apital city of the smallest state, but I have no rea to believe it to be unique in Australia. There is a strong commitment to medical ethics and to a compassionate profession. I have never experienced refusal of cooperation between hospitals or "rival" doctors. Th certainly are competing medical insur companies, but they compete in the serv es they offer. They rebate money to patients, rather than paying doctors, so companies cannot interfere in medical decision making.

The great adv ntage of our system is freedom to practise medicine as I wish to practise it and to compete against my fellows in the quality of service I offer. This is an incentive to keeping waiting time to a minimum; to keep wards, consulting rooms, and waiting rooms clean, cheerful, and comfortable; and to communicate clearly and courteously with patients and the general practitioners who refer them.

The patients, most of whom are insured for private hospital care, have freedom to choose their general practitioner and their specialist, which hospital they prefer, and the date on which admission would be convenient. The biggest blot on our system is that not everyone can afford to be fully insured. They must accept what the public hospital system provides, which does not offer freedom of choice. If freedom of choice is the hallmark of a truly democratic society the most obvious way to improve our system would be to extend full medical and hospital insurance to all, regardless of income, so that even the poorest have the same choices as everyone else.

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Training in obstetrics and gynaecology

SIR,—Mr J D Hamlett (30 April, p 1256) is concerned about the "decline in number and quality of junior staff" in obstetrics and gynaecology and the excessive workload and antisocial hours in the specialty. I think I may be one of the "inadequate" junior staff whom he describes as I have many "faults in the basic human material available for training." Let me describe my experience of working in a department of obstetrics and gynaecology as a senior house officer on a vocational training scheme.

One of my "faults" is that I need to sleep at night. Nevertheless, I was expected to work for three days and two nights with little sleep during weekends on call. There was a gross imbalance between the service and training components of my job. I spent 84 hours each week on call and got 15 minutes of formal teaching. The consultants showed little interest in theoretical teaching and none at all in bedside teaching. Nobody ever watched me examine a patient. Is it surprising that I was less "adequate" than I should have been? And I was not unique: senior house officers are abused in this way all over Britain.

Most of Mr Hamlett's suggestions are sensible. Of course the job should be structured to provide sensible hours of duty, workload, and sleep. I particularly like his idea of a one in five on call rota and a day off after a night on, but I hope that his proposal applies to junior staff as well as to consultants.

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Points

After the horror

Dr RITA HENRYK-GUTT (Shenley Hospital, Radlett, Hertfordshire WD7 9HB) writes: Professor Beverley Raphael and Dr Warwick Middleton (23 April, p 1142) draw attention to the difficulty that sometimes occurs in diagnosing post-traumatic stress as a cause of psychological distress. There is now evidence that the effects of such trauma may extend to the children of the victims, and this needs to be recognised when they experience psychological problems in adult life. The work on this relates in particular to the children of survivors of the Holocaust.[1,2] Some of the problems relate to disturbed family relationships resulting directly from the psychological symptoms of the parent. There is also the difficulty the second generation experiences in accepting the victim as "a good enough parent."[3] This seems to produce a feeling of the world as dangerous and life as insecure, leading to depression and anxiety requiring treatment. This problem of the second generation is not generally recognised by doctors in Britain, and this may preclude correct diagnosis and appropriate treatment.

1 Bergmann MS, Jucovy ME, eds. *Generations of the holocaust*. New York: 1982.
2 Barocas HA, Barocas CB. Wounds of the fathers; the next generation of holocaust victims. *International Review of Psychoanalysis* 1979;6:331.
3 Bettelheim B. *A good enough parent*. London: Thames and Hudson, 1987.

Cervical cytology screening

Dr DAVID SLATER (Department of Histopathology, Rotherham District General Hospital, Rotherham S60 2UD) writes: The organisation and results of the British Columbia programme described by Dr George H Anderson and others (2 April, p 975) are impressive and invite comparison with the British programme.

British Columbia and other countries, including Iceland,[1] with broadly similar programmes provide further evidence that high compliance (80%) and frequent recall (every one to three years) will achieve a large reduction (72-78%) in mortality from cervical cancer. The continuing laissez faire British policy[2] will have some effect but, tragically, substantially less than in Canada. Patient compliance and recall frequency are independent factors in the equation of success, and it is illogical for the government to resist mandatory increased frequency of recall because of variable compliance. The Canadian policy of concentrating cytological skill in large central laboratories has advantages. This opportunity was lost in Britain with devolution to health districts. The computer is the central pivot in the Canadian laboratory and there is extensive and adequate technical and clerical help. In Britain, although computerised call and recall are now mandatory, laboratory computerisation for adequate follow up and fail safe mechanisms remains desirable but optional.[2] The British Society for Clinical Cytology recommendations on laboratory staffing[3] are comparable to those for Canada—even down to screening one slide every eight or nine minutes. Sadly, however, these recommendations fall well short of practice in most British laboratories.

1 Laara E, Day NE, Hakama M. Trends in mortality from cervical cancer in nordic countries association with organised screening programme. *Lancet* 1987;i;1247-9.
2 Department of Health and Social Security. *Health services management cervical cancer screening*. London: DHSS, 1988. (HC(88)1.)
3 British Society for Clinical Cytology. *Recommended code of practice for laboratories providing a cytopathology service*. London: BSCC Publication, 1986.

Charges for dental examinations

Dr M J ALDRED and Mr P J M CRAWFORD (Department of Oral Surgery, Medicine, and Pathology, Dental School, Heath Park, Cardiff CF4 4XY) write: We are concerned by the comments attributed to Dr L Osborne regarding dental examinations and their effect on dental health (23 April, p 1207). Dental examinations should not be regarded solely in relation to caries. They are important in the recognition and referral of, among other things, premalignant and malignant oral conditions. What evidence supports Dr Osborne's contention that dental examinations are less essential than sight tests? Furthermore, although water fluoridation is of undoubted benefit in reducing dental caries, fluoridated water is available to only a minority of the population of the United Kingdom. The decline in the prevalence of caries in recent years cannot, therefore, be attributable to this single cause. Given the government's declared commitment to prevention of disease, it seems paradoxical that charges for any screening examinations should be proposed. Are cervical smears to be the next item to attract a charge?

Disabled living centres

Professor W A WALLACE (Department of Orthopaedic and Accident Surgery, Queen's Medical Centre, Nottingham NG7 2UH) writes: Dr M A Chamberlain discusses the development of disabled living centres and their value in providing a display of "tools for living" and valuable information of all types for the disabled. There is, however, an error in her map of the location of disabled living centres as a number of newer ones are now being opened. In particular, a resource centre for the disabled was opened in Nottingham in 1987, and Nottingham should be recorded on the map as having a full disabled living centre.

Correction

Urinary catheters

We regret that an error occurred in this letter by Dr D J Vaughan and others (30 April, p 1258). The first sentence of the second paragraph should have read: "Chlorhexidine may not only be inhibited or inactivated by urine itself; up to half of all catheter specimens of urine may contain organisms resistant to this antiseptic."