mammogram was over 80 years old and operation was not considered justifiable; and in the others we doubted the significance of the microscopic findings in the absence of significant clinical abnormality.

Altogether 105 patients needed no treatment other than a single aspiration of their cyst. Follow-up of these women for six months or up to two years in those over 40 years disclosed no further masses at the sites of the original cysts. In three of the 15 patients who were followed up for over a year further cysts developed at other sites; these were also treated by primary aspiration.

Discussion

Provided certain precautions are taken the treatment of breast cysts by primary aspiration is simple, safe, and inexpensive. In a large series reported recently no cancers developed at the sites of previous aspiration.[2] As cysts of the breast are always multiple[3] it may be considered illogical to treat them otherwise, particularly when resources for inpatient surgery are in short supply. Careful examination of the breast after aspiration for a residual mass and after an interval for refilling of the cyst and mammography or xeromammography are essential safeguards.

Routine cytological examination of the cyst fluid has not proved valuable. Only one of the four patients with cancer had cytological abnormalities and, conversely, several with abnormal cytological findings proved not to have cancer. Microscopy for red blood cells also proved difficult to interpret; a few red cells are often present as a result of the needle puncture. In all four patients with cancer the presence of blood was gross, and simple biochemical assessment seems to be adequate. Spectrophotometry is under study.

Needle aspiration of all discrete lumps in the breast at the patient's first attendance has many attractions. By immediately defining whether a mass of the breast is solid or cystic it is a useful diagnostic procedure, and finding a solid lesion immediately indicates the need for biopsy. If cancer is suspected we often follow this by a Tru-cut needle biopsy. Though the cytological examination of the needle aspirates may lead to a firm diagnosis,[4 5] the smears are difficult to interpret and we prefer the greater certainty of a histological diagnosis. Needle aspiration also allows immediate recognition and definitive treatment of cysts of the breast. All women coming to a breast clinic with a discrete lump in their breast are anxious, and immediate assurance at their first attendance that the lesion is only a cyst and that the likelihood of cancer is very small brings welcome relief.

We thank Professor E. Samuel and Dr. G. B. Young of the department of radiology in Edinburgh and Professor K. Evans and Dr. H. Gravelle in Cardiff for the mammograms. We also thank Professor A. R. Currie and Professors J. Gough and D. Williams of the departments of pathology in Edinburgh and Cardiff for routine reporting of smears.

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Letter from . . . Canada

The Hot Stove League

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British Medical Journal, 1975, **3**, 31-32

Economics is not taught in medical schools. Most doctors would prefer to get on with their work and leave any financial finanglings to somebody else. Medical economics has never been quite respectable. World-wide inflation is rapidly changing this attitude. Ivory towers can get a little drafty.

So soon as a paying agent, be it a government or an insurance agency, appears between a doctor and his patient that doctor is forced to negotiate his fees. Increasingly through the Western world the paying agency is a monopoly government employer against which a highly individualistic profession is at a considerable disadvantage.

In Canada we have 10 separate provincial medical insurance schemes, partly funded by the federal government. Each province negotiates separately with its doctors, and with 10 separate negotiations going on each year we are building up a considerable body of experience. National conferences on negotiation and collective bargaining, in which in the 10 provincial branches of the Canadian Medical Association pool their knowledge, are paralleled by the federal-provincial meetings of health ministers.

Some lessons have already clearly emerged. One organization must negotiate for the whole profession. When there is lack of unity between specialists and general practitioners, as in Quebec, one side can be played off against the other. Academic colleges have weighty responsibilities in the fields of medical standards and medical education but they should not be involved in negotiations. In Canada 30% of physicians are salaried. They have long ago realized that their reward is directly related to the earnings of non-salaried physicians. It would be frank hypocrisy to deny this. In several provinces the salaried physicians have asked the medical associations to negotiate on their behalf. In Newfoundland the final stage has been taken by the government as part of a settlement with the profession. All Newfoundland doctors have to belong to the Newfoundland Medical Association, which is recognized as the sole bargaining agent. While many feel that this takes the profession away from the tradition of a voluntary association and towards that of a trade union, there is no denying that the bargaining position of the Newfoundland doctors has been strengthened.

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Mechanics of Negotiation

In an effort to relate professional income to the earnings within the community during an inflationary period negotiation becomes extremely complex. Indices of living costs, wages and salaries, gross national product, and disposable income are quite unfamiliar to us. Governments have a massive bureaucracy at their disposal that thrives on such esoterica. The Canadian Medical Association has found it very necessary to develop a department of research and development which supplies its 10 provincial divisions with all the information necessary, including an independent look at the construction of any government statistical data. This is expensive but very worthwhile.

While the associations are backed by their own statisticians, economists, and lawyers it is still better that respected physicians be the actual negotiators. Lawyers negotiating on our behalf encourage the government to employ other lawyers, who then proceed to exchange expensive letters between themselves. It is better to have doctors in eye-to-eye confrontation with politicians. They make the final decisions. The setting up of review bodies, commissions, and other political phantasmagoria is merely a device for procrastination and those of us who have served on such bodies are very aware that there is no such thing as their independence.

It is very important that a time interval be set between negotiations—"Don't phone me, I'll phone you" is a favourite political device. It results in delay, so that finally the profession has to ask for a massive percentage increase which embarrasses the doctors and which the politicians find it politically easy to deny. The device of referendum to the membership to confirm a settlement is still experimental in Canada. We have learned the referendum has to be simple. Yet this simplicity precludes a discussion on paper of the complexities of the issues. In a small province it is probably better to have a specially attended general meeting where all can hear the arguments, but in the larger provinces we are still experimenting with these referenda.

Professional Independence

The ultimate strength of the professional case must depend on public opinion. This demands that we give good service and that we be reasonable. The public, our patients, have to be prepared to pay the cost of our services one way or another. Government insurance mechanisms merely allow them to do it collectively. The final freedom of the profession to return to a direct financial relationship with their patients is a freedom that most Canadian doctors do not wish to utilize. Nevertheless our freedom to do this is the key to professional independence, and professional independence is essential to our patients as well as to us. Once we lose it we are incapable of protecting our patients against any lowering of standards caused by governments trying to cut costs.

During my training in London I never heard one of my teachers mention fees—let alone their negotiation. Those surviving, beloved in the kindly perspectives of memory, will shake their heads and say economics has nothing to do with good medicine. Abernethy and Paget were not concerned with rewards. With ingrained respect, I suggest they are wrong. A profession that feels itself unfairly rewarded does not function at its highest levels of performance. Delusions of scientific altruism will not keep the doctor warm while unscrupulous politicians remove his shirt.

Aspects of Sexual Medicine

Some of the Commoner Sexual Disorders

II. Problems Mainly Affecting the Woman

R. W. TAYLOR

British Medical Journal, 1975, 3, 31-34

Expectation

Gynaecologists have in the past been made aware of a woman's sexual problems only if they produced symptoms and in particular if they gave rise to pain. There is a wealth of literature dealing with vaginismus and dyspareunia, for example.[1-4] Increasingly today's practitioners are being confronted by frigidity and the marital problems it sometimes brings in its train. A consideration of a woman's sexual problems must therefore be concerned with the question of her expectation of sexual enjoyment and the degree to which it is fulfilled, as well as dealing with those problems which have either a physical basis or a clear physical manifestation.

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Orgasmic Failure

By the nature of her biological responsibilities a woman's reproductive function can be separated from her enjoyment of intercourse. Nature can be served whether or not she achieves any satisfaction; even her consent is unnecessary. Though there is obviously a paramount physical element to sexual satisfaction, and a rhythm of response associated with the ovarian hormone cycle can sometimes be found, psychological factors are also very important in the majority of women. Circumstances can therefore determine the woman's response in a way they do not in the man. Psychological factors may certainly influence his reaction, particularly if he is inexperienced or has a low sexual drive, but in general orgasm is determined by the degree of physical stimulation. Add to these things the fact that the physical response in woman is usually much slower to develop than that in man, and many of the elements which might contribute to a woman's dissatisfaction with intercourse are plain to see.

Failure to achieve orgasm can be primary or secondary. When it is primary in the sense of always having been present it will