clinical service. With decentralised budgets this management task would lie with budget holders who would be more likely to know the staff and to know what flexibility was viable and desirable. Such controls would make the policy more acceptable to the Treasury and would not undermine the freedom of manoeuvre wanted by managers.

I believe that the general thrust of the Warlow report deserves support, and it is important to state this to a medical audience—because the report is damaged by several recommendations on medical terms and conditions that are couched in simplistic terms and written in a somewhat offensive language. The report accuses consultants of resisting reductions in juniors' hours because it would mean an increase in consultants' own workload. Royal colleges are accused of having a negative influence on job descriptions that may lead to the closure of clinical services and unnecessarily high levels of medical staffing and also of playing an inappropriate part in limiting the performance of medical staff. Many of the issues Warlow raises are the old chestnuts such as the holding of contracts at district level, and most of them have already been discounted or rejected in the recent agreement on new job descriptions between the profession and the Department of Health.

What most doctors will see as crucial, however, is the implication for their pay—based for 30 years on recommendations from an independent review body—of the proposed greater flexibility and of pay funds. If present arrangements continue the separation of doctors' pay from other conditions of employment would effectively prevent them participating in the type of local packages envisaged; and yet such packages might help with recruitment problems to registrar posts in some specialties and with staff grade recruitment. The advent of NHS trusts and their freedom to determine medical pay and conditions will further destabilise present arrangements, and as the number of trusts increases the universality of Doctors and Dentists Review Body awards will diminish. One way to create more flexibility for doctors while retaining the neutral and independent role of the Doctors and Dentists Review Body might be to limit that role to determining the percentage size of the increment and to illustrating what this might mean for consultants still retaining traditional salary structures. Even such a limited change would be repugnant to many doctors who have seen national rates of pay as ensuring an even distribution of doctors throughout the country. The alternative, however, is the gradual erosion of the review body's influence as trusts shape new and more remunerative forms of medical contracts. When the National Health Service and Community Care Act 1990 finally gets its royal assent the profession will have to consider seriously the future role of the review body. This may not be as alarming as some traditionalists might think. The review body's supporters may well be embarrassed to find that these changes will begin to show the extent to which the review body has held down doctors' salaries in comparison with other senior NHS staff and non-NHS managers and professionals.

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Traveller mothers and babies

Health authorities need to provide better care

There are at least 12 000 traveller gypsy caravans in Britain.[1] This community of over 60 000 people belongs to one of Europe's oldest and most marginalised ethnic minorities.[2] Like other groups on the edge of our society, including the homeless,[3] they have difficulties gaining access to health care.[4,5] Despite the introduction of specialist traveller health visitors in some health authorities[6] many travellers still do not benefit from regular medical services, and many authorities have no policy on health care for this community.[7]

A recent report from the Maternity Alliance took a broad view of the maternal and perinatal health care provided for travellers.[8] The fact that this group suffers poor health has already been well described.[9,10] To its credit the Maternity Alliance did not go over that evidence again but instead looked at possible underlying factors. The report reminds us that the health of pregnant travellers and their babies depends partly on the facilities and environmental conditions of caravan sites: that is, the presence or absence of hot and cold running water, electricity, regular rubbish collection, and functioning toilets. Past studies have described the poor facilities found particularly on unofficial sites,[9,11] and the Maternity Alliance claims, firstly, that many sites are still inadequate and, secondly, that the number of sites provided is insufficient for the traveller population. The report emphasises another factor that undermines maternal health and also jeopardises the provision of antenatal and perinatal care—the forcible eviction of traveller families from unofficial sites. "The best and most accessible antenatal care is of little avail if a mother is continually moved from one health district to another."[8] Travellers need secure and safe stopping places.

The Maternity Alliance prompted the Association of Metropolitan Authorities to survey its members about provision for traveller families. The survey found that, of 43 responding authorities, almost a third would evict pregnant women "close to birth," and more than a third would evict pregnant women or mothers with a newborn baby. At least the metropolitan authorities replied; the Association of County Councils and the Association of District Councils "seemed unwilling to give any priority to investigating their members' policies with regard to Traveller mothers and babies."[8]

The report moves beyond a critique of health and local authority policy (or apathy) towards travellers to positive recommendations. For local authorities these range from the development of "non-harassment" policies for pregnant or newly delivered mothers on temporary sites to the provision of basic environmental health amenities and regular liaison with health authorities and representatives of local travellers. The report calls on health authorities to include travellers' needs in the planning of services, to name a person to coordinate information relating to travellers, and to liaise regularly with local authorities, family practitioner com-

mittees, and travellers themselves. Such recommendations are more than pious hopes: the report describes various health and local authority initiatives in Essex, Medway, east London, East Anglia, Sheffield, and Liverpool as examples of good practice. They should encourage other authorities to take the plunge.

One of the unresolved issues for travellers' health care is the balance between specialist "outreach" services such as mobile health caravans[5] and integration into existing general practice and community health services.[12] Integration is hampered by discrimination on the part of some health care providers as well as the mobility of travellers, their lack of postal addresses for appointments, and their low literacy rate. Travellers also have different cultural perceptions of health and illness from most health workers.[13] These barriers to health care require imaginative solutions, such as the use of hand held medical record cards and mutual education of travellers and health care providers. Sadly, the new contract for general practitioners may inadvertently discourage the registration of travellers, especially in practices struggling to meet immunisation and cytology targets.

We need research on travellers' health needs and health perceptions as well as evaluation of interventions such as hand held record cards, educational initiatives, and increased liaison between different agencies concerned with travellers' health. Already, however, we know enough for authorities to take action. The government's new health service legislation charges district health authorities with responsibilty for assessing the health needs of their populations and purchasing the appropriate services. The Maternity Alliance report is a timely reminder to health authorities not to overlook the needs of travellers.

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Management of menorrhagia

Hysteroscopic techniques offer a revolution in treatment

Excessive menstrual bleeding is a common complaint of women during their reproductive years and accounts for many consultations.[1] Unfortunately, the history is a poor index of genuine menorrhagia as only two fifths of women who complain of flooding, the passage of clots, and heavy use of tampons or pads actually lose more than 80 ml of blood per cycle—that is, more than the 90th centile limit for a normal population.[2,3] Although the history is a better indicator of menorrhagia in the presence of pelvic disease, particularly uterine fibroids,[4] the only reliable way of confirming the diagnosis is by measuring the blood loss.[5] Such measurement, however, remains essentially a research tool, although various modifications of the commonly used alkaline haematin method have been suggested for everyday use.[6] A more realistic diagnostic aid is the assessment of blood haemoglobin or serum ferritin concentration as two thirds of women with objective menorrhagia suffer from iron deficiency anaemia.[2] Recently, pictorial menstrual charts have been described that may also improve diagnostic accuracy.[7]

Once menorrhagia has been diagnosed its cause needs to be identified. The common causes include fibroids, endometriosis, endometrial hyperplasia, and, in the absence of identifiable disease, "dysfunctional uterine bleeding."[8] A general examination looking for signs of hypothyroidism or a bleeding tendency should be combined with pelvic assessment and, because of the potential risk of endometrial malignancy or premalignancy, with outpatient endometrial sampling in women aged over 40.[9] Dilatation and curettage is not only unnecessarily invasive but it also offers no guarantee of detecting intrauterine disease[10,11] and is not therapeutic in most cases.[12] Instead, there is increasing evidence that hysteroscopy, carried out as an outpatient procedure, is the best technique for assessing the endometrial cavity, endometrial polyps and submucous fibroids being found in up to half of all patients with menorrhagia.[13,14] The possible role of psychological factors should also not be forgotten.[15]

Treatment should take account of the likely diagnosis as well as the age of the patient, her desire to maintain fertility, and the presence of other symptoms such as prolapse. There are several effective treatments, though there is no scientific evidence for the effectiveness of the most commonly prescribed agents—progestogens such as norethisterone.[16] Interestingly, intrauterine contraceptive devices that release progestogen seem to be effective, and the newer formulations are not associated with a high risk of ectopic pregnancy.[17] There is objective evidence for the efficacy of the combined contraceptive pill[18]; prostaglandin inhibitors (mefenamic acid,[19] naproxen,[20] indomethacin,[21] ibuprofen,[22] flurbiprofen,[23] meclofenamate sodium[24]) even in the presence of an intrauterine contraceptive device[21,25-27] but not of fibroids[22,28]; and antifibrinolytic agents (ε aminocaproic acid,[29] tranexamic acid[30]), which may also be effective in cases of menorrhagia induced by intrauterine contraceptive devices[31,32] and the capillary stabiliser ethamsylate.[33] All these agents reduce menstrual blood loss by an average of 50%. Danazol[34] and luteinising hormone releasing hormone agonists[35] may be even more effective and produce amenorrhoea, but short term and long term side effects preclude their prolonged use. The newer agent gestrinone may prove to be better tolerated but be equally effective (M C P Rees, personal communication), even to the extent of reducing the size of fibroids.[36] Tamoxifen,[37] vitamin E,[38] and subcutaneous desmopressin[39] have also been tried in special cases with apparent success.

Medical treatments are, however, neither curative nor