	Optical Density Difference at 450 mμ	Bilirubin Content (mg/100ml)			Zone (Liley)
		Total	Direct	Indirect	
Left twin	0·455	0·54	0·12	0·42	Lower III
Right twin	0·310	0·28	0·05	0·23	Upper II

aborted hydropic twins and was subsequently sterilized.

In this case, unlike the one we reported in our first letter, it was hoped that accurate assessment and adequate treatment would have been possible because of the position of the sacs, side by side, and the position of the placentas (posteriorly).—We are, etc.,

EVELYN M. MCNICOL
ANDREW AULD

Robroyston Hospital,
Glasgow

Detecting Sickle Haemoglobin

SIR,—Dr. James Bowman's objection to solubility tests—automated or not—for HbS mass screening purposes (9 September, p. 644) is most welcome. The defects of such tests, results of which are used for genetic counselling, cannot be exposed too vigorously if only because the whole screening/counselling procedure as it is now avidly practised has usually led, in Dr. Bowman's own words, to "socio-economic trauma through bogus education, erroneous diagnosis, and inept counselling."

Much of the socio-economic trauma is directly due to failure to draw a distinction between the sickle-cell trait and sickle-cell disease in spite of the fact that world experts like the Colonial Medical Research Committee Working Party on Sickle-cell Trait and Sickle-cell Anaemia,[1] and the World Health Organization[2] have clearly separated the *trait* and the *disease*.

From America, too, Dr. Beutler and his colleagues[3] have commented recently on a Massachusetts law which states in part that "Every child, which the commissioner of public health, by rule or regulation, may determine is susceptible to the disease known as sickle-cell trait or sickle-cell anaemia, shall be required to have a blood test. . . ." They state some of the hazards known to them to have occurred as a result of sickle screening as (1) loss of employment because of the detection of sickle-cell trait; (2) discontinuation of medication by a middle-aged patient with cardiac disease because cardiac symptoms were falsely attributed to sickle-cell trait; (3) perforation of the appendix of a child because his abdominal pain was falsely attributed to sickle-cell disease when he had, in fact, sickle-cell trait; and (4) long delay in the adoption of a child because it was discovered to have sickle-cell trait.

In Ghana, where one in three of the population is either sickle-cell trait or haemoglobic-C trait, solubility tests have no place in surveys aimed at genetic counselling because the non-sickler is by no means necessarily a normal homozygote (AA). Moreover, as Dr. Bowman rightly pointed out, these tests are incapable of telling the sickle-cell trait (AS) from sickle-cell haemoglobin-C disease. The gene frequencies ($n_S=0·1$, $n_C=0·5$, $n_A=0·85$) in Ghana, for instance, are such that SS=SC=1%—that is, exactly the same number of sickle-cell anaemia as sickle-cell haemoglobin-C patients are expected at birth. If a screening test cannot tell these SC patients (1% of all births) from AS individuals it is not favoured here for genetic counselling.

Finally, one other important objection to unsolicited screening is the unexpected traumatic effect on the equanimity of the family. In these days of increasing infidelity in married life how would one explain to the non-sickling parents the finding that their school child was sickling positive? Was it, in fact, a mutation?—I am, etc.,

F. I. D. KONOTEY-AHULU

University of Ghana Medical School,
Accra, Ghana

1 Woodruff, A. W., *et al.*, *British Medical Journal*, 1957, 1, 1235.
2 W.H.O. Scientific Group Report. *Haemoglobinopathies and Allied Disorders*. Technical Report Series, No. 338, pp. 40, Geneva, W.H.O., 1966.
3 Beutler, E., *et al.*, *New England Journal of Medicine*, 1971, 285, 1485.

Jaundice after Anaesthesia

SIR,—Last year I reported[1] that we were investigating the causes of jaundice occurring within a month or so after anaesthesia, regardless of the anaesthetic agents used. We are particularly concerned to obtain evidence about hypersensitivity responses and variations in metabolism of anaesthetic agents in jaundiced patients. The first part of the investigation has been completed, but recent developments in the field of immunology have encouraged us to continue with a second phase of the study.

Blood and urine samples are needed for the investigation, and one of the team of Drs. Walton, Strunin, and myself is prepared to travel anywhere in Britain and Eire to prepare, store, and transport the necessary specimens, subject to the prior approval of the clinician responsible for the patient. I would be most grateful, therefore, to any clinician for telephone or postal notice of the occurrence of jaundice, under the circumstances outlined above, in any patient under his care.—I am, etc.,

B. R. SIMPSON

Anaesthetics Unit,
The London Hospital,
London E.1

1 Simpson, B. R., *British Medical Journal*, 1971, 3, 189.

Late Onset Psychosis in Children

SIR,—In his article on late onset psychosis in children (30 September, p. 816), Dr. J. Kolvin writes that "analytical psychotherapy has so far made no contribution." However, he does not mention the great advancement in our understanding of the psychotic process as a result of the work of Melanie Klein.[1] This work is not just of theoretical interest but has important clinical applications. There exists a substantial group of adolescents suffering from schizoid personality disorders. They lead an isolated existence, have profound difficulties in forming relationships, and at times exhibiting frankly psychotic symptoms, but it is uncommon for them to progress to schizophrenia and phenothiazines are not helpful. However, using Kleinian object-relation theory it becomes possible to understand their psychopathology and they can then be helped by outpatient psychotherapy.

With supervision I have treated 10 such patients in the last year in the Maudsley psychotherapy department, and have seen a resulting improvement in each case.—I am, etc.,

R. LUCAS

Maudsley Hospital,
London S.E.5

1 Segal, H., *An Introduction to the Work of Melanie Klein*. London, Heinemann, 1964.

Mechanics of Elastic Bandaging

SIR,—I was most interested in Mr. H. D. Johnson's comments on bandaging (23 September, p. 767). This is yet another light on an old problem. The physiological rationale of the "perfect" bandage has been investigated in detail[1-3] and it would seem from independent methods that a hydrostatic or G-suit type of stocking is best. Using hydrostatic stockings the bandage pressure at any point in the limb equals the intravascular hydrostatic pressure, independent of posture or movement. This gives maximum support and least disturbance to blood flow.

Unfortunately, appliance manufacturers have ignored the difficult technical challenge which this presents and we are left with the rather inadequate rule-of-thumb alternatives described by Mr. Johnson.—I am, etc.,

A. D. B. CHANT

Surgical Division,
University of Southampton

1 Chant, A. D. B., *British Journal of Surgery*, 1972, 59, 552.
2 Chant, A. D. B., *British Medical Journal*, 1970, 2, 235.
3 Wood, J. E., *Scientific American*, 1968, 218, 86.

M.A.O.I. Treatment Cards

SIR,—There are at least two cards which may be given to patients taking monoamine oxidase inhibiting drugs. There is the one circulated by the Department of Health and produced with the approval of the B.M.A. and the Pharmaceutical Society, and the one (which I use myself) issued by the Association British Pharmaceutical Industries (A.B.P.I.).

The former one, which is used by many general practitioners, does not mention alcohol or broad beans as being contraindicated. I am aware that it is the broad beans plus pods, cooked while they are young and tender, that contain the offending tyramine which has the pressor side effect on patients who are taking M.A.O.I. drugs, but the complete absence of the mention of alcohol as being contraindicated has astonished me and several of my colleagues both in psychiatry and general practice. The A.B.P.I. card is more comprehensive and contains the substances which most of us know are contraindicated. I presume that an up-to-date card will be prepared by the industry. In recent years other items of diet such as certain types of tinned fish, stewed bananas, and various types of pickled fruit and vegetables have been incriminated as causing a reaction. These reactions may be minimal and occur only in certain indi-

viduals, but I think that attention should be drawn to the omissions on the cards and that they are rectified as soon as possible.—I am, etc.,

E. S. LAMONT

Herrison Hospital,
Dorchester, Dorset

Immunochemotherapy of Cancer

Sir,—In your leading article and a paper by Professor T. Ghose and others on the immunochemotherapy of cancer (26 August, p. 486 and 495) no mention appears to have been made of some recent work[1] on attaching a boron compound directly to an antibody protein. Boron-10 strongly absorbs thermal neutrons which give rise to high energy α-particles. It was found that boron bound to an antibody was 500 times more effective in destroying target cells than non-specifically-bound boron. Furthermore, it is suggested that the use of a highly enriched boron-10 compound may render this method five times more effective still.

This work thus demonstrates a method with a very high selectivity for cellular destruction which offers a third approach to the immunochemotherapy of cancer, complementing the two methods of Professor Ghose and his colleagues—namely, the use of antibodies for the attachment of a radiotherapeutic agent or a cytotoxic drug.—I am, etc.,

A. MANOLIS

Stanmore, Middx

1 Hawthorne, M. F., Wiersema, R. J., and Takasugi, M. *Journal of Medical Chemistry*, 1972, **15**, 449.

Student's View of Reorganization of N.H.S.

SIR,—It has been obvious for many years that the National Health Service requires radical reorganization to meet the changing health needs of the population. The Government White Paper[1] is totally inadequate to deal with these problems because: (1) Patients are ignored. "It is about administration and not about treatment and care." (2) It is based on the principle of "maximum delegation downwards matched by maximum accountability upwards"—a total reversal of the democratic process. The community health councils give only lip service to consumer control, having no powers, no funds, and being appointed by the area health authorities. (3) It supports the continued domination of the N.H.S. by private practice and the teaching hospitals. (4) It pays no attention to the immense problems of finance that already exist in the N.H.S. (5). The two main objectives of the White Paper will not be fulfilled. The tripartite system of the N.H.S. will not be unified because the public health service is excluded and the general practitioner service is only nominally included. The new local government authorities are not directly linked to the proposed area health authorities.

These are the main points on which we base our opposition to the White Paper, and we urge Parliament and the medical profession likewise to oppose its implementation.—I am, etc.,

JOHN R. KIRWAN
Vice-president,
on behalf of the Executive Committee,
British Medical Students' Association

Tavistock Square,
London W.C.1

1 *National Health Service Reorganization: England*, Department of Health and Social Security, 1972. Cmnd. 5055, London, H.M.S.O.

B.M.A. Deputizing Services

Sir,—Dr. I. W. B. Grant (30 September, p. 833) takes exception to an advertisement offering over £4,500 for a 65-hour week with a deputizing service. He seems disturbed that any doctor should work a 65-hour week and he is under the misapprehension that most of it is on night duty. We live in a real rather than an ideal world, and deputizing services employ doctors in a real situation. The dockers might be able to work a 35-hour week but doctors are not in this happy situation. The average hospital doctor certainly works for 65 hours, and if one is to accept their overtime payment system one should consider 65 hours as a short week. General practitioners certainly work for more than 65 hours. The regulations prevent a general practitioner from using a deputizing service on every night and every weekend, but even if the practitioner were to flout this regulation he would still reduce his working week to only 65 hours.

An average doctor working for 65 hours with a deputizing service would perform an average of only 14 of those hours between midnight and 7 a.m., and he is in the happy position of not having to work the following morning. The advertisement refers to "over £4,500." In practice the figure is likely to be over £5,000, but we have to quote the lowest sum possible to ensure that we do not inadvertently mislead. We compute a working week on the basis of these hours because experience has shown that the average doctor wanting a full-time position wishes to do at least that number. He can work fewer if he wishes and he will be paid pro rata.

Dr. Grant thinks this is "hardly a princely remuneration for an experienced doctor." The duties of a deputy are indeed arduous from time to time but are not on average more burdensome than those in any other active field of medicine. The deputy's responsibilities are obviously considerably less than those of a principal in general practice and yet the salary is not materially less than that earned by the average general practitioner. At the same time, the salary is materially higher than that paid to the vast majority of hospital staff. The hospital rates are those agreed between our negotiators and the Department of Health and it cannot therefore be wrong to advertise hours and rates which compare favourably with other relevant branches of the profession.—I am, etc.,

M. J. OGNALL
Deputizing Service Director

Scarcroft,
Leeds

New Consultant Contract

SIR.—In a previous letter (16 September, p. 704) I stated that the whole-time consultant's legal commitment to the N.H.S. was 168 hours a week and that the belief that his working week was divided into 11 notional half days was mistaken. Dr. R. Vaughan Jones (30 September, p. 832) disagrees, and in support of his view he quotes the reply of the Secretary of State for Social Services to a question in the House of Commons on 28 April 1969 (*Supplement*, 15 July, p. 40).

I regret to say that both the Secretary of State, who employs no consultants, and Dr. Vaughan Jones are mistaken and that a misconception held by the Secretary of State is no less of a misconception. I would agree with Dr. Vaughan Jones that a consultant's moral commitment to his patients is unlimited, but if any whole-timer still has doubts about his legal commitment he should read his contract or, better still, get his solicitor to read it for him.—I am, etc.,

N. A. SIMMONS

Potters Bar, Herts

SIR,—Your critical correspondents on this important matter regrettably do not offer any alternative constructive suggestions. Surely no one believes that the present contractual arrangements are acceptable to all the profession. Not only is the present contract "open-ended," it is almost deliberately imprecise. Neither the B.M.A. nor the Department of Health are able to give precise interpretation on several important aspects. Who understands Categories I and II? Some teaching is remunerated, some is not. Cover for absent colleagues has no limits. The dissatisfaction expressed highlights the present ineffective representation of senior hospital doctors. Clearly up to the present our "negotiators" have not always been able to foresee the immediate and long-term effects of some of their agreements. Moreover, the present contract can be said to be divisive.

Under its loose terms contractual commitments of young consultants appointed in 1972 are different from those appointed several years ago. Additionally different boards are able to interpret the so-called agreements in different ways. Whether or not the present contract is acceptable clearly depends on personal circumstances. What our aim should be is to achieve a contract which will most nearly adapt itself to the needs of all and will at the same time encourage consultants to think and act collectively for the benefit of all. The present contract certainly cannot be said to do this.

The proposals contained in the "Consultants Charter," published by the Regional Hospitals' Consultants and Specialists Association early in 1971, were arrived at after lengthy discussion and after a referendum of all members. Only those proposals receiving a 66% majority of those replying have been adapted as R.H.C.S.A. policy. The B.M.A. proposals, published several weeks later and ratified at the Annual Conference of Hospital Medical Staffs in November 1972, are almost identical.

Our suggested contract is not a device to increase remuneration per se. It is our attempt to define contractually the duties to be expected of any individual consultant, defining committed sessions and "on call" liabilities without disturbing the principle of the "notional" session and "continuous patient care." If this is achieved then it will not be possible for the Department and