rightly draw the conclusion that lack of professional concern is partly due to failure to appreciate the use of well-validated developmental tests on the child.

Psychologists and clinical medical officers have a great deal to offer in relation to the measurement of mental growth, even in the very young child, through testing and the observation of the status of the child's behaviour and play. The physical effects of abuse and deprivation are there to be seen even postmortem, but equally observable are signs of overall behavioural immaturity or specific immaturity.

Whether the aetiological causes arise from within the child or from without secondary social problems arise. The parents, who may have limited understanding and no insight with their problem, sometimes react highly and emotionally or primitively. It is strange that society lays less blame at the door of more careless parents—for example, those involved in road traffic accidents.

It is generally accepted that all children ought to be subject to brief developmental screening. Those with special needs, be they physical, social, or to do with mental ability, can be separately assessed in great depth on the Griffiths Mental Developmental Scale, as Dr. Smith and Mrs. Hanson have demonstrated. Given astute professional advisers we may expect advice to be available to those parents and children in need. It is usually only psychologists and specially trained (mostly self-trained) doctors who have the impartiality which makes them accessible. At least it should be part of the new community paediatric service to make such advice available where and when it is most needed—that is, in the context of services available to all children. Only in this way will advice be available soon enough or often enough.—I am, etc.,

BRIAN H. BURNE

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Tests of Thyroid Function

SIR,—We were interested to read the paper by Dr. C. W. H. Havard and Miss Margot Boss (14 September, p. 678) in which it was stated that similar information to that provided by the thyroid-stimulating hormone (TSH) stimulation test may be obtained by the measurement of serum TSH levels before and after the injection of thyrotrophin-releasing hormone (TRH). In our paper,¹ to which they refer but unfortunately misinterpret, a single estimation of serum TSH, and not the TSH response to TRH, was as valuable as the time-consuming TSH stimulation test in the assessment of thyroid reserve. In our experience, in the investigation of suspected hypothyroidism no additional information is gained by estimating the TSH response to TRH unless to attempt to differentiate between pituitary and hypothalamic hypothyroidism.

In the following issue (21 September, p. 708) Dr. E. G. M. D'Haene and his colleagues did not find as good a correlation between the effective thyroxine ratio (E.T.R.) and the free thyroxine index F.T.I. as previously reported. They did not, however, assess the diagnostic accuracy of either test on the grounds that an objective measurement would be compared with a subjective clinical impression. They there-

fore have no basis for assuming that the F.T.I. is the better clinical test. In a recent report² we could find no difference in diagnostic accuracy between the E.T.R. and the F.T.I. measured in 100 consecutive patients referred to the thyroid clinic. The thyroid status in these patients was determined not only by subjective clinical means but also by other in vivo and in vitro tests of thyroid function such as plasma TSH estimations and radioiodine uptakes with triiodothyronine (T-3) suppression and TSH stimulation if required. Since the E.T.R. has the advantage over the F.T.I. of being both a one-stage procedure and yielding a more rapid result we still prefer it to the F.T.I. as a screening test of thyroid function. Indeed, we have stopped using serum T-3 uptake measurements for some two years, these being perhaps indicated only if one suspects a diagnosis of binding protein abnormality that has not been induced by pregnancy, oral contraception, or other medicaments.—We are, etc.,

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- 1 Irvine, W. J., et al., *Clinical Endocrinology*, 1973, 2, 135.
- 2 Toft, A. D., et al., *Clinical Endocrinology*, 1973, 2, 127.

C-Film as a Contraceptive

SIR,—In April 1973 the Family Planning Association started a clinical trial to try to assess the efficacy and acceptability of C-Film used as a sole method of contraception. This trial was carried out at the request of the manufacturers of C-Film, Potter and Clarke Ltd., and with their financial support for which we are most grateful.

To be eligible for recruitment to the study a woman had to be aged 16-35 years, to have a stable sexual relationship, and to have had no exposure to oral contraceptives for at least one cycle. All those who entered the study volunteered to do so. On admission a history was taken from each subject, paying special attention to vaginal discharge, pruritis vulvae, and venereal disease. Any history of balanitis, genital pruritus, or venereal disease in the subject's partner was also recorded. After a gynaecological examination the woman was taught how to insert C-Film and written instructions on the use of the contraceptive were given to her. These included the following points: (a) that one C-Film should be used for each act of intercourse, (b) that no other contraceptive should be used during the period of the study, and (c) that a monthly record card should be kept to note the dates of menstruation, the days on which intercourse took place, whether C-Film was used for each act of intercourse and which partner used it, the presence of vaginal symptoms, and whether

other methods of contraception were used (despite instructions to the contrary). Finally, each woman was asked to return to the clinic at three-monthly intervals. Sixty-three subjects entered the study. Of these, 18 were not included in the analysis—three because they never used C-Film, six because they were lost to follow-up, and nine because they failed to keep their record cards satisfactorily. It may be noted that the nine subjects in the last category completed at least 19 months of use of C-Film between them and that, to the best of our knowledge, none became pregnant.

Of the 45 subjects included in the analysis, all had regular menstrual cycles, 23 were nulliparous, and one was lactating at the time of enrolment. Nine of these women experienced an involuntary pregnancy during a total of 175 person-months of exposure to risk, representing a use-effectiveness pregnancy rate of 62 per 100 woman-years. Two pregnancies occurred during the first month of use, one during the second, two during the fourth, and the remainder during the fifth or later months. In only one case did the woman admit to having had unprotected intercourse; the remaining eight women stated that C-Film was always used. In addition to the nine women who became pregnant, a further 25 withdrew from the trial—four because of side effects (irritation and discharge), two because of the difficulties with the method, and 19 for reasons not connected with the method.

During a total of 185 cycles of use C-Film was always used by the female in 109 and always by the male in 15. In six cycles C-Film was always used by both partners, in 47 the pattern of use was "mixed," and in eight it is unknown which partner used C-Film. It has been suggested that male use of C-Film offers less protection against pregnancy than female use. Accordingly, in the assessment of the nine involuntary pregnancies particular attention was paid to which partner had used C-Film during the cycle of conception. In five cases C-Film was used exclusively by the female, in three the pattern of use was mixed, while in only one case could we establish exclusive male use during the cycle of conception. Though the subjects were instructed that no other method of contraception should be used for the trial period several did use other methods on odd occasions during a total of 18 cycles. In these instances other contraceptives were generally used instead of rather than in addition to C-Film. In none of the nine involuntary pregnancies was another method of contraception used during the cycle of conception.

In spite of the fact that the women were carefully taught how to use C-Film, several complained of difficulties in inserting the film properly. This and the fact that C-Film may not always dissolve completely may be responsible at least in part for the high failure rate.

In view of the unacceptably high failure rate the F.P.A. decided to terminate the study in June 1974. The association does not recommend the use of C-Film as a sole method of contraception to women attending its clinics. Whether C-Film has a role to play as an adjunctive to other methods of contraception remains to be seen.—We are etc.,

Family Planning Association,
London W.1

M. SMITH
M. P. VESSEY
W. BOUNDS
J. WARREN

Economies in the N.H.S.

SIR,—I am prompted to write in support of the letter by Dr. H. P. Hughes (5 October, p. 41) suggesting that there should be a reappraisal by the Law Society, B.M.A., and medical defence societies on what might or might not be considered negligence in failing to x-ray an accident case. There are, without doubt, a great number of unnecessary examinations carried out at the request of inexperienced casualty officers because they fear litigation. Apart from the waste of money, these requests are a source of further unrest among radiographers, who

often have had considerable experience of trauma and who know that the x-ray examination requested is unnecessary. In fact, during the radiographers' strike many of the accident cases sent away never came back again.

Another factor seldom considered is the question of exposing the patient to unnecessary irradiation. *The Code of Practice for the Protection of Persons against Ionising Radiations*¹ states: "The clinician requesting the [x-ray] examination of investigation must satisfy himself that it is neces-

sary." Another waste of money is the growing tendency to have routine chest x-ray examinations done before even a minor operation such as varicose vein stripping or a hernia repair. This seems unnecessary, as the result of the x-ray examination seldom seems to influence the course of the operation.

One can only hope that some learned judge should soon make a casualty officer legally liable for having subjected a patient to unnecessary irradiation rather than haranguing him for not having had the patient x-rayed.—I am, etc.,

M. C. CONNELL

Northampton

¹ Department of Health and Social Security, *Code of Practice for the Protection of Persons against Ionizing Radiations arising from Medical and Dental Use*. London, H.M.S.O., 1972.

Doctors' Pay

SIR,—Few now argue with the fact that doctors in this country have fallen at least 20% behind in the pay race. Recent awards to other groups make our 12% total over the past two years look absolutely ridiculous. Many groups, of course, such as industrial managers and other professions, have had the opportunity since the ending of stage 3 to correct their own shortfall, but we have to rely on the Review Body procedure. Based on previous experience I would like to make a forecast of coming events.

About the end of November (or later according to *Pulse*) Lord Halsbury will produce his review. Should it be unfavourable to us it will be published immediately. Otherwise the Government will keep it to themselves until the Christmas recess. A fortnight or so after Parliament reassembles, in answer to a question, the Prime Minister will announce that in his view it would be better to deal with the doctors' pay at the time the next review takes effect on 1 April. He will explain with reasonableness that after all this is only a few weeks away. During February and March there will be a period of severe industrial action by those unions concerned with the supply of power and about mid-March the Government will introduce a total freeze on salaries and wages to be followed after a few months by a statutory policy. The Prime Minister will be very apologetic but will explain that of course doctors are not among the lowest paid members of the community and that as they are a loyal and dedicated profession he is quite sure that they will accept the situation.

Is it too much to hope for that, just for once, our negotiators should inform the Prime Minister that unless, as the unions say, there is "money on the table" by November we shall no longer operate the N.H.S.? Have no doubt the money would be there.—I am, etc.,

J. M. LONDON

Redditch

SIR,—Dr. R. D. H. Ryall (12 October, p. 109) demonstrating an attitude that has always perplexed me, urges us to emphasize our poverty to the public and compare our situation to that of our overseas colleagues.

What perplexes me is that we constantly compare our pay and conditions with those of doctors in other countries. What Dr.

Ryall and many others do not realize, including the public thank goodness, is that in other countries we are *not* doctors. (I am excluding underdeveloped countries where it is not possible to exist without one's own Government's support or that of a charitable agency.) In competitive markets such as the U.S.A. or Canada our degrees are hardly worth the paper they are written on. There one must almost completely retrain and sit very difficult examinations before being allowed practise on the open market. (How many readers have seen an American State Board examination paper?) True, it is possible to emigrate to the Arctic circle, but try getting your degrees recognized in Tennessee, Chicago, or Montreal.

In Europe, and no thanks can be offered to the B.M.A. for recognizing and hastening the implementation of the Treaty of Rome's proposals, we are faced with a similar picture. Finland excludes all foreign medical graduates by statute. France, with the exception of two overpublicized clinics for foreign nationals in Paris, also does not recognize foreign medical graduates; it is a technical offence to claim to be a doctor at a road accident in France unless one is a French doctor. The Low Countries have stiff language examinations and prohibitive premiums of up to £20,000 to buy into a practice, from which one must have been offered a job before registration is granted. Germany is overdoctored and Italy boasts one doctor to every 300 people. Spain lacks the legal machinery to admit foreign doctors to work. Sweden and other Scandinavian countries admit a few anaesthetists for work in remoter areas as locums.

We must realize that we are alone, our degrees unrecognized, and in the hands of a monopoly employer, the State. This State monopoly will, with the help of its handmaidens the sociologists and community physicians, erode further the standing and worth of the British medical degree in the eyes of the international medical community, using cash shortage to replace doctors, independent professionals, with State-controlled and State-paid paramedical workers.

Dr. Ryall now wants us to admit we are poverty-stricken so that the status-conscious and greedy British public, which, like all publics from Caesar to Wilson, measures a man's success by his bank balance, can see we are failures. To admit failure is to fail, and to fail is to be a failure. Thus though we have constantly used the non-existent threat of emigration to win the public's support, though there is nowhere to emigrate to, let us not try the role of the beggar on the public or they may rumble the other lie.

I urge all my colleagues to press for early recognition of our degrees in Europe. Only with that recognition of the right to practise in Europe can we have a valid yardstick by which to measure our pay and conditions against the State monopoly.—I am, etc.,

MYLES F. HARRIS

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SIR,—I have read with interest the letter from Mr. A. F. Robinson (5 October, p. 48). Though he agrees that disparity exists in the earnings of various hospital consultants because of additional remuneration from domiciliary consultations and merit awards, he wants to justify it on the basis that the

clinicians are in clinical charge of patients after a long and rigorous selective training. The comment regarding differences in professional ability and skill may have been true at the turn of the century but they were probably untrue in 1948 and are certainly not applicable to 1974. The fact is that all consultants have to go through an exacting selection technique used by examining bodies and long, arduous training. The length of preconsultant training may vary by a year or two, at the most, in some more popular specialties because of greater competition. The consultants who stay longer in preconsultant training are duly compensated and are given up to four increments at the time of appointment. Remuneration from domiciliary consultations is not meant to compensate for longer preconsultant training.

Frankly, I do not understand what is meant by "rigorously selective training" and "grounding in the complexities of dealing with the great British public," since general practitioners without such training are able to deal with them. However, most clinicians will agree that they will not be able to stop medical bucks without the help of the "ancillary and subcontractual specialties."

It is my considered view that a system of remuneration which allows a substantial additional sum of money to be earned per year, amounting to 25% of a full-time consultant's maximum salary, and provides better pension benefits for the rest of life for certain groups of consultants is quite unjust and basically wrong in principle. I am sure that the domiciliary system is largely abused and that the occasions when a G.P. really needs assistance and the patient cannot attend the hospital are very few. I do not see any reason why these few patients in need of urgent consultation or opinions cannot be brought to the hospital for assessment. The money thus saved can go towards the improvement in basic salaries of all consultants, as pointed out in the letter from Dr. S. Mehta and others (14 September, p. 690).

Applied consultant egalitarianism will not only solve the problem of recruitment in less popular specialties but also, above all, will help to unite the profession.—I am, etc.,

R. S. NARANG

Wigan, Lancs

A Bad Week

SIR,—I read with great interest the letter by Dr. A. A. Stephen (19 October, p. 169). I fully endorse every point he makes regarding the abuse of the N.H.S. and am greatly concerned about its future.

Though I am a foreigner, my feelings for the welfare of Britain and her people are no less genuine. A few months ago I joined general practice after a year as a trainee. I am appalled by the abuse and the exploitation of the service, probably one of the best in the world, by a considerable section of the population. These people, ill-educated and ignorant beyond belief, are under the misapprehension that doctors, particularly in general practice, should be at their beck and call 24 hours a day.

I have learned from life that, in general, people do not appreciate things for which they do not have to pay. If every patient,