scribed in the subchondral osseous plate and trabecular bone1 were present in all 17 patellae.

Although the treatment is problematical, promising results have been obtained with gradual quadriceps exercises and intra-
muscular nandrolone propionate.—We are, etc.,

J. DARRACOTT
McMaster University, Hamilton, Ontario, Canada

B. VERNON-ROBERTS
The London Hospital, London E1

1 Darracott, J., and Vernon-Roberts, B., Rheuma-


2 Robinson, A. R., and Darracott, J., Annals of

Rheumatic Diseases, 1971, 30, 286.

3 Ovre, A., Acta Chirurgica Scandinavica, 1936,

77, Supplement 41.

Screening for Cervical Carcinoma

SIR—I cannot help but feel that the Depart-

ment of Health and Social Security is being

hypocritical about the screening of women

for carcinoma in situ of the cervix.

At the Council meeting of 31 January 1973 Dr.
J. C. Cameron announced that agreement had
been reached with the Department
regarding an extension of “public policy” in
that payment would now be made for two
further groups of women: (1) women over 35
on the quinquennial anniversary of their
birthday, irrespective of whether or not they
had been screened in the intervening period
or not; and (2) women under 35 who had had
three or more pregnancies. Dr. Cameron
explained that the latter group had been in-
cluded on the grounds that women who led
active sexual lives were at greater risk than
the nulliparous (Supplement, 10 February,
p. 41). If this is true, while one applauds any
move to extend the scope of screening for

carcinoma of the cervix, one cannot con-
done illogical thought. The fact that a
woman under 35 has had three or more

pregnancies just does not mean that she leads
a more active sex life than the one with

fewer or no children. Someone must really
whisper the facts of life in the ear of the

D.H.S.S.

In 1968 I drew attention to the high in-
cidence of carcinoma in situ in young
women.1 This has been noted by most other
observers too and is emphasized by Dr. E.
Ann Tait in her letter (3 February, p. 296).

In my own survey of 700 women at risk
there were 14 with positive smear; six of
these were under 35 years of age and in-
cluded two girls aged 17 and others aged
20, 22, 26, and 29 years respectively.

If the Department is reluctant to extend
“public policy” to screening of all women
irrespective of age because of economic con-
siderations it should be honest enough to
declare this. The medical profession must
reject pseudoscientific claims. The Govern-
ment is shirking the failure of the Department to take heed of
well-documented clinical observations of

many workers in this field.

RALPH A. R. LAWRENCE
Lesbrooks, Derby

1 Lawrence, R. A. A. R., Journal of the Royal

College of General Practitioners, 1968, 16, 379.

Management of the N.H.S.

SIR.—Wise patients normally follow their

doctors’ advice. Management in the N.H.S.

are responsible for seeing that the patients

in their care receive good medical treatment,

and if wise will want to be guided by their

medical staff in matters which directly or

indirectly affect patients’ medical welfare. It

is to be hoped that this has been fully

appreciated in the imminent reorganization of

the Service. I would like to draw attention to

one facet of the problem.

The object of the hospital and domiciliary

services has been defined as provided by

primarily by clinicians. Clinicians are re-

sponsible, morally and legally, for the care

of patients. They know most intimately their

needs and the investigatory and therapeutic

requirements to meet these needs. One

would have expected, therefore, that clinicians

would have been given a large say in manage-

ment, at least at district level where the work

of the Service will largely be carried out.

Management, however, is to be in the

hands of a district management team con-

sisting of four administrators assisted by

one general practitioner representing anything
from two to 30 G.P.s and one consultant

representing anything from 50 to 100 con-

sultants. Between them these doctors will be

responsible for the care of tens of thousands

of patients annually. The team is to be con-

sidered as responsible both legally and theo-

retically for the proper management of their
district but also with the continuous forward planning of medical

dservices therein. It is hard to believe, with

the complexity of modern medicine, that anyone
could have thought of this as a satisfactory

arrangement, likely to result in an efficient

service or to engage the enthusiastic support

of clinicians. To suggest such a minimal role

for the 300-400 doctors who will actually be

responsible for the remedial care of perhaps a

quarter of a million potential patients is

surely a trifle absurd.

While the broad outline of the proposed new

management structure cannot be altered,

much detail is still open to discus-

sion. Perhaps the proposed composition

of the district management team is no more

than a negotiating position. Certainly it is

up to consultants and G.P.s in the districts
to do their utmost to persuade the propos-

altered to something which more nearly

corresponds to the realities of patient care.—I am, etc.,

DAVID FERRIMAN
London N.W.5

Ten-session Consultant Contract

SIR.—We should like to add our voices to

the growing volume of disagreement with

the proposed new consultant contract.

We accept that there is a problem to be

solved, in that consultant manpower is

unequally distributed in Britain and some

consultants work much longer hours than

others. The acceptance of additional N.H.S.

commitments (such as abortions and vasec-

tomy) without any increase of staffing com-

pounds the problem. The solution proposed

in the new 10-session contract is to specify

the number of hours for which a consultant

must work in order to earn his basic salary

and to pay him for additional out-of-hours

work. We find this suggestion disastrous.

It will involve the profession in an un-

professional approach to the care of patients and

will progressively diminish our independence.

Who will certify that our extra-duty claims are

reasonable? It will not be long before we are

"locking in" and obtaining certifi-
cates of attendance from the appropriate

duty administrative officer.

The details of the new contract must be

settled before it is price. It appears un-

likely that it will result in a significant in-

crease in the total sum available for remun-

eration of consultants. The basic salary will,

therefore, tend to be reduced, and consul-

tants will be in competition with each other

for their share of the "over-time" or "extra-

duty" moneys. It is a disturbing thought

that there will be a financial incentive to

postpone urgent work till after normal

working hours.

We are equally disturbed by the proposal

that even full-time consultants will have

the right to see private patients and to

retain the fees. Although theoretically private

practice after working hours is not incom-

patible with N.H.S. responsibilities, we be-

lieve that in many specialties there is a con-

flict of interests which will be to the detri-

ment of the Health Service.

We have not yet met a large group of

hospital staff who are in favour of the new

consultant contract. Certainly in the teaching

hospitals (where we work) opinion appears to

be overwhelmingly against the features we

have commented on. We unapologetically lux-

climated overworked consultants in under-

staffed regional hospital, but there must be

better ways of helping than those proposed in

the 10-session contract. In addition, the

new contract would open a gap between

N.H.S. staff and their university colleagues,

which would weaken the medical schools

and hamper improvements in medical edu-

cation, both undergraduate and postgraduate.—

We are, etc.,

I. BOUCHER
L. BELLIN
J. LORBER
W. GREIG
R. SHANKS
R. LOWE
C. WHITE

Association of University Clinical Academic Staff,

King’s College Hospital Medical School,

London S.W.1

Points from Letters

The Disease of Alcoholism

Dr. J. W. Too (Farnham, Surrey) writes:—

Does the view that alcoholism is a disease

improve the prospects of recovery? I know of

no evidence that it does, and I suspect that

it may well have the opposite effect. If the alco-

holic is constantly told that he is the victim of

a disease, which carries the implication that he

is a helpless victim who must be cured by the

efforts of others, is he likely to acquire the con-

viction that he is the over-riding prerequisite for

recovery—that he must stop drinking for ever?

Alcoholism

Mr. M. BRUDENELL (King’s College Hospital,

London S.E.) writes: Mr. H. P. Dunn (27

January, p. 237) argues that the proposition

that the best prophylactic against postabortion

sterility is adequate contraception to prevent

unplanned pregnancy is invalid, because as

contraceptive advice is disseminated the abor-

tion rate goes up. Surely the point is that the

abortion rate goes up only in those not prac-

tising contraception. Every doctor in this

country dealing with patients requesting abortion

is aware how often the unplanned pregnancy

results from a lack of contraception.