A venogram showed right subclavian thrombosis. Urokinase was infused intravenously, and by the 4th hospital day, a third venogram showed that most of the thrombosis had cleared. At this time, her right upper extremity was much improved clinically with decreased swelling and less tenseness and tenderness. She was able to move her fingers freely. The urokinase drip was discontinued, and she was continued on heparin drip and subsequently discharged on oral warfarin for 3 months. After 3 months of oral therapy, she was reevaluated by vascular surgeons. At that time, she underwent a first rib resection to prevent further injury. She is currently asymptomatic.

Robert J. Darios, M.D.
Sparrow Hospital
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Pap Smear Adequacy

To the Editor: Thanks for the relevant and clear article on "Papanicolaou Smear Adequacy" (July – September 1989). Certainly, the suggestion of more aggressive use of available collection technology is very well taken. Not only do reports of "no endocervical cells" strain followup systems and cost extra money, but they cause needless anxiety.

When I did a study of 600 samples obtained by 20 practitioners in our HMO in 1983, I found that, aside from a correlation of endocervical cells and blood (presumably because of more aggressive scraping, because relation to menses, etc. was not a factor), the most important single factor that correlated with the presence of endocervical cells was the technician involved! Unfortunately, 4 technicians were used in my study, and their percentages were 63, 68, 83, and 90 percent, with a significance of $P < 0.001$ between the latter three (unpublished data). The laboratory representatives, when questioned, said they did not find such variability, but there is no other simple way of explaining my data.

Dr. Noel notes that 2 technologists were used in the study. I believe this might affect his data. More to the general point, I believe that laboratories have a much greater variance between technologists than they realize, and this may affect the "adequacy" of Pap smears more than any other factor.

Alan Steinbach, Ph.D., M.D.
Berkeley, CA

The above letter was referred to the author of the article in question, who offers the following reply:

To the Editor: I appreciate Dr. Steinbach's letter regarding my study. As he states, reports of "no endocervical cells" do strain followup systems, cost extra money, and cause anxiety. Most importantly, though, these reports potentially indicate that a cervical carcinoma has gone undetected.

In his unpublished study, Dr. Steinbach apparently has found significant variability among technicians in reporting the presence of endocervical cells. This problem of intertechnologist variability has been reported previously, and knowledge of this problem was incorporated into the planning for the study published in *JABFP*. In my study, although 2 cytotechnologists were used, 1 cytotechnologist screened all of the slides for the first 5 months of the study and the other cytotechnologist screened all of the slides for the last 2 months. Thus, only 1 cytotechnologist was screening the slides at any given time. The potential confounding variable of inter-rater reliability was controlled for by randomizing patients to either one of the two techniques and using a single cytotechnologist who was blinded to the technique used. For this reason, inter-rater reliability did not affect the data. Even though there may have been some variability among the cytotechnologists, I still found that there was a true difference in the adequacy of Papanicolaou (Pap) smears attributable solely to the instrument used.

Based on this data, I am confident that using the cervical cytobrush for Pap smears increases the rate of recovery of endocervical cells, which improves the detection of cervical dysplasia.

Michael L. Noel, M.D.
Baylor College of Medicine
Houston, TX

Any More Cordials to the Drooping Spirit

To the Editor: I read and re-read your recent editorial (July – September 1989) and thought it was *excellent*. Your presentation of the modern doctor-patient relationship was a perfect image placed in context.

As chairman of our hospital Ethics Committee, I plan to make your (to me) stinging question, "Can they [values] be nourished by the ideals of competence and accountability in a market economy?" the topic of our next meeting. Also, because some of your discussion was about patient autonomy, I wonder if you would agree that the transition from medical paternalism to autonomy to state paternalism is not necessarily an advance?

John Davenport, M.D., J.D.
Irvine, CA

Editor's Comment

Thank you for your letter. Your last sentence poses a question that goes beyond my editorial, a question about the relative merits of differing ethical values, in this case, patient autonomy versus two varieties of beneficence. (I interpret paternalism to be an authoritarian form of beneficence.) Such a question, as I understand it, belongs to the metaphysics of morals rather than to normative ethics or to metaethics. (See Rakel RE, Conn HF, eds. *Family Practice*. Philadelphia: W.B. Saunders, 1978:Chapter 17.)

You imply that substituting patient autonomy, as a higher ethical value, for physician beneficence is not necessarily a bargain; moreover, that patient autonomy is already being displaced by another form of beneficence that is even less virtuous. Whether you are correct in this opinion I cannot say, but I agree with your pointing out that the next round of debate about medical ethics will include analyzing the ethical status of what we have already decided to be ethical.

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