Indeed, Mr Wright's reaction seems to make the case for outsiders like myself to inquire into policy issues: while we lack "practical experience," we also lack the biases of those involved in running the NHS and may thus contribute a more temperate and objective point of view.

RUDOLF KLEIN

Centre for Studies in Social Policy,
London WC1

[1] Klein, R, *Complaints Against Doctors*. London, Charles Knight, 1973.

Evidence to Royal Commission

SIR,—About a year ago the BMA began the task of preparing evidence for presentation to the Royal Commission on the National Health Service. This preparation soon affected many of the members of the Association's central committees as well as thousands of ordinary BMA members up and down the land. A good deal of the time of the secretariat has been devoted to this exercise. And indeed persons entirely outside the Association, some with little sympathy for many of its past activities, were nevertheless persuaded to contribute to the process so that at least the arguments could be displayed in full.

In the case of our own central committee a working party spent many hundreds of man-hours commissioning, reading, occasionally writing, and editing the evidence it received. Eventually this, together with all the other "preliminary" BMA evidence, disappeared into the six panels and has re-emerged entitled "draft evidence" (29 January, p 299) in the form of perhaps the largest collection of sacred cows ever herded together by the Association. We are not sure quite how the BMA might have gone about the task of producing evidence which showed that for once the medical profession was closely identified with the health needs of the people at large. What is apparent, however, is that much time, effort, and money would have been saved had the secretariat simply been empowered to string together the familiar collection of specious claims, essential prejudices, tired old shibboleths, etc, which now constitute the evidence. We suggest that in future files be maintained at Tavistock Square specifically for purposes such as this and that once every 100-200 years they be updated.

SPENCER HAGARD

Glasgow

STEPHEN D HORSLEY
Trainee Representatives,
Central Committee for Community Medicine

Harrogate

World Medical Association

SIR,—Dr E B Lewis (5 February, p 394) is, I believe, a member of the BMA Council and is presumably one of the members who voted that the BMA should withdraw its support from the World Medical Association. You quote him as saying that "a World Medical Association which did not include the Soviet Union, China, and the USA was merely a grandiose title of a sounding board for windbags, which the WMA had become."

I entirely agree with him that the WMA can hardly claim to represent the doctors of the world if the Chinese, Russian, and American medical associations are not members. But I fail to see how withdrawing BMA support will help to put this right.

If Dr Lewis had been at the WMA Assembly at São Paulo last October, as I and several other BMA members were, he would know that it was decided, following a motion put up by the Scandinavian medical associations, to seek ways and means of bringing in the Eastern-bloc medical associations. As for the American Medical Association, there are already signs that they are feeling left out in the cold (for example, American doctors had no opportunity to present their views on interrogation to the United Nations Commission on Human Rights). Does Dr Lewis want us to be similarly left out of the mainstream of developments? If he wants the WMA to be stronger and more influential he is not being very helpful. The WMA costs each BMA member but two Swiss francs per annum. Is there a single doctor who begrudges that contribution?

J RIBEIRO

Cardiff

Revising the salary structure

SIR,—This would appear to be the year of the "differentials." In the immediate past salary negotiations for doctors working in the NHS have become fragmented. Surely, in considering the claims of any particular group, the whole salary structure should be examined and reviewed. The professional ladder must be seen to be worth climbing to encourage the ambition of the many talented younger doctors. Starting at the top, salaries for junior, newly appointed consultants should start at £25 000, rising to £35 000 with seniority. The higher the top rung, the better for the many on the lower rungs.

A general practitioner for 27 years, I am impressed by the younger generation of hospital consultants. They marry their expertise in modern medicine to wit, culture, and charm. It is a pity to see the gradual souring by frustration and dismay at their abysmal reward.

J A CHISHOLM

Nottingham

Profession and Government

SIR,—I deprecate your decision to print the "Charles Hastings" letters under a pseudonym. Much of what was said was contentious and parts, particularly of the third letter (22 January, p 246) were malicious.

Over the past decade British medical practitioners have been subject to both political and professional pressures from within and from outside the medical profession, and it is particularly necessary at this time that practitioners should not tolerate anonymity of speakers on political and professional matters, particularly in a leading professional journal. The vital care of patients is too important for it to be put at such a stake. Over the last few years we have seen the introduction of health centres, the discouragement of single-handed practices, the reorganisation of the NHS, and now the imminent introduction of the recommendations of the Court Report. By these moves the Government has cut off financial support for the profession from local government sources and has stifled and virtually extinguished the opinions of the public health service, latterly called the community health service, that sought to speak for the total population it served. There will shortly be a virtual monopoly of medicine by the Department of Health and Social Security and the bureaucrats who run it. If the present Government succeeds in its object the only practising doctors who will not be whole-time servants of the DHSS will be, firstly, some general practitioners, and secondly, those hospital doctors employed by the universities and the Medical Research Council, and they too hold honorary contracts with the DHSS.

I submit, therefore, that "Charles Hastings," if he had any strength of character or honour within the profession, should not have been so cowardly as to hide behind a pseudonym. Already we are ruled not by our consciences but by politics and expediency. Practitioners must not be afraid to acknowledge their opinions, or their opinions will not be worth acknowledging.

SONIA G BOLTON

Child Health Service,
Central School Clinic,
Portsmouth

Dispensing practices—unfair pricing

SIR,—Some doctors may be unaware that during the past 12 months the profitability of dispensing has decreased progressively as the wholesale prices of drugs have increased. This is because manufacturers' price rises taking place before the 8th of a given month are not taken into account by the pricing bureau until the following month, and those taking place after the 8th not until the next following month.

As some rises of the order of 20% have taken place recently the profitability has almost vanished altogether. If doctors will check the figures supplied to them on form FP 34 (part B) they will find the average pricing of a prescription by dividing item 1 by the number of prescriptions shown alongside. This has risen from approximately £1·10 in January 1976 to £1·40 in October 1976.

The pricing of drugs should take into account this effect of inflation and should correspond with the wholesale prices current at the time of dispensing each prescription. Otherwise some doctors will find themselves dispensing at a loss in the near future.

H K DAVISON

Billesdon,
Leicester

Posthumous pensions

SIR,—A member of the Association for 50 years, I have hitherto resisted any impulse to write to you, but I am now impelled to support Dr W H Gossip (12 February, p 448).

The delays in implementation of increases of pension are frustrating. The BMA's acceptance in principle of the Health Departments' proposals for war service increase in pension was announced in the *BMJ* of 20 September 1975 (p 720). In the *BMJ* of 27 November 1976 (p 1337) it was stated that amending regulations were "not likely to appear in print before about March 1977." This date now appears to be "about May 1977." Many of those who could have received an increase in pension have died. It is difficult to understand why women widowed since

July 1975 should be deprived of benefit from their husbands' war service.

Interest at 3·5% compound, without tax relief, payable to secure war service pension compares very unfavourably with the miserable 2½% simple—taxable—paid since 1948 on our compensation for loss of goodwill.

A colleague of mine with six years of war service recently wrote to the appropriate department of the Ministry of Defence seeking confirmation of the dates of his war service. I understand that the reply was to the effect that "they had never heard of him."

Reverting to the increase of pension of practitioners who retired between January 1969 and March 1972, I wrote to the Superannuation Department which deals with my pension in March 1975 and even at that late date they denied any knowledge of the proposed increase. Why are we waiting?

K FORSYTHE

Comrie, nr Crieff,
Perthshire

Reorganisation in North Yorkshire

SIR,—Part of the report "From the CCCM" (5 February, p 397) reads, "Finally, the committee discussed one of the personal tragedies that occurred during the reorganisation of the NHS. The discussion was prompted by a letter received from a doctor in North Yorkshire."

Although there were more than enough disasters as the result of reorganisation, the letter referred to was not intended to arouse sympathy. It was concerned with financial matters in respect of one person. If the CCCM feels so strongly as to use emotive words like "tragedy" it is, perhaps, not too much to expect it to take some action.

What happened to the medical staff of the North Riding of Yorkshire may be no more than a reflection of the shabby standards of much of public life, but that is all the more reason why the representatives of the medical profession should not allow those events to pass without comment. At this late date nothing can help those who were so shamefully treated but, should our representatives prove so weak as to appear to condone this whole sordid affair by their silence, it would be tragedy indeed.

W R M COUPER

Pickering, N Yorks

Points from Letters

Smoking and mortality in British doctors

Dr M A KASTENBAUM (Tobacco Institute Inc, Washington, DC) writes: The recent publication (25 December, p 1525) by Sir Richard Doll and Mr Richard Peto is just one in a long series of articles by the first author and others on the effect of smoking on British doctors. From the very beginning statisticians have raised questions about the adequacy of the original sample to represent the population of all British physicians in 1951. The crux of the problem lies in one sentence, repeated again in the introduction to the current article—namely, "Replies that were sufficiently complete to be used were received from 34 440 men—that is, about 69% of the men who were alive when the questionnaire was sent." . . . If the sample of British doctors had indeed been selected at random in 1951, 69%, or perhaps a much smaller percentage, would have been more than adequate for most of the generalisations that have been made during the past 20 years. However, this was not the case. The respondents to the mail questionnaire were voluntary, a fact that raises all sorts of unanswered questions about biases, not only among the 69% who responded but also among the unknown 31% who failed to respond. The sentiment of reputable statisticians on this form of sampling bias has been repeated ad nauseam in statistical and sample survey literature.[1] [2] . . .

[1] Hill, A B, in *The Application of Scientific Methods to Industrial and Service Medicine* (Medical Research Council), p 7. London, HMSO, 1951.
[2] Bryson, M L, *American Statistician*, 1976, **30**, 184.

Natural curing of tobacco and lung cancer

Dr G Y CALDWELL (Singapore) writes: . . . The Semai tribe of Malaysia start smoking as early as two years old, when they give up breast-feeding. It is a sort of weaning. At the age of 22 they have smoked for 20 years and at 42 for 40 years. In a recent survey when the whole tribe of 12 000 had their chests *x*-rayed not one showed any trace of lung cancer. The rural environment no doubt is in their favour, but could not the local-grown, nature-cured tobacco also be a contributory factor to their good health? . . .

Postural imbalance in the elderly

Dr MABEL L HAIGH (Wetherby, Yorks) writes: In the article by Dr P W Overstall and others (29 January, p 261) maybe more emphasis could have been put on the significance of the natural aging processes in the central nervous system and in particular those in the vestibular system. The relationship between the gross anatomy and histology of the vestibular system, as also its physiology, and that of the organ of hearing would seem to run very close. . . . It is perhaps not surprising that evidence of "swaying" indicative of diminishing vestibular function may . . . occur as early as 40 years of age. . . . It would have been interesting to know how closely the hearing of patients studied by audiometric tests correlated with the results of the tests described for monitoring "swaying" as the loss of hearing occurring in the elderly is probably not of sudden onset but develops gradually from middle age onwards. And just as it is important to encourage the elderly with hearing loss to wear a suitable heraing aid so perhaps it would be helpful to suggest that balancing exercises be included as a routine—unless, of course, there is some contraindication—in physiotherapy arranged for the elderly.

Arthroscopy of the knee

Dr D J STOKER (Royal National Orthopaedic Hospital, London W1) writes: Mr S C Gallannaugh (12 February, p 445) believes that the advantage of arthroscopy over arthrography lies in the fact that the surgeon can identify the meniscal lesion before proceeding to operation. Perhaps because he is less often engaged in diagnostic procedures than we radiologists he neglects to discuss the negative arthroscopy. Other arthroscopists[1] have reported that in over a third of patients arthroscopy does not affect the management. These authors state that its chief advantage is the identification of those patients in whom a proposed arthrotomy is unnecessary. This is equally true of arthrography which, as an outpatient procedure, does not have the disadvantages of using theatre time and staff, general anaesthesia, and significant short-term morbidity. . . .

[1] Dandy, D J, and Jackson, R W, *Journal of Bone and Joint Surgery*, 1975, **57B**, 346.

Distinction awards

Dr A H MIAN (Hemlington Hospital, Middlesbrough) writes: In their examination of the distinction awards system Drs P Bruggen and S Bourne (12 February, p 462), being psychiatrists, obviously have an interest in pointing out the unfair differential between psychiatrists and other disciplines in the medical field. However, going through the paper as well as the table I do not see any mention of diagnostic radiology at all. As everybody knows, this is one of the shortage specialties which is in crisis. I would like to know how this specialty compares with other specialties in medicine. . . . My purpose in writing is to urge not only that a fair method be devised for merit awards, but also that the secrecy surrounding it be abolished. . . .

Call to negotiators

Dr M WYNN (Buckie, Banffshire) writes: May I set down a few points to stiffen the resistance of those who would negotiate on our behalf in the next round of pay talks with the Government? . . . No one can doubt our patriotism as a profession considering that we have accepted the excuses of the politicians for nil awards and refusals to accept Review Body recommendations, all for the good of the economy. At the same time, to make up for these deficiencies I am forced to bear the burden of an ever-increasing bank overdraft . . . To add insult to injury I find that the bank rate and consequently mortgage rate are being held at an artificially high level by the Bank of England. I am now in a position whereby, to keep the NHS going, I must subsidise it from my own pocket and at the same time pay penal rates of interest for the privilege of doing so. . . . To our negotiators I would say, force the Government to reintroduce proper pay differentials; ignore the bleatings of those who would impose a prices and incomes policy. How can any government claim that wage rises cause inflation when, with virtually stagnant incomes, inflation is running at 30%? . . . It seems to me that all is not yet lost. The juniors, who won a great victory over the politicians last year, will eventually find their way into more senior posts both medical and medicopolitical. They will not have forgotten the methods which won them a victory. I feel sure that should they retain this sense of purpose in their more mature years, then we shall have the nucleus of a negotiating machine with real backbone. Unfortunately for a great number of the profession, by the time these people become politically effective it will be too late. . . .