ance to consider politically unpalatable ways of supplementing central NHS funding of hospitals.

(1) *Payment by the hospital outpatient.* At a notional rate of £2·60 per first consultation this could yield £21·49m a year nationwide or £26 000 to a hospital with 10 000 new outpatients annually.

(2) *Payment by the hospital inpatient.* (*a*) A standard charge of the 4-8% of the daily "bill" spent on bed and board could, on 1974 figures,[2] yield over £124m a year nationwide or nearly £146 000 to a 500-bed general hospital with average bed occupancy. (*b*) The amenity-bed sector should be expanded, each inpatient paying a larger proportion of his "bill." (*c*) The pay-bed sector, far from being phased out from the NHS campus, should also be expanded. The yield could greatly exceed the "undisputed" £20m a year (23 October, p 1017).

(3) *Subscription of professional fees.* Doctors treating pay-bed patients on NHS premises should subscribe a proportion (one-third?) of their professional fees to their local hospital supplementary fund.

(4) *Road accident levy.* The existing enactment should be more rigorously enforced and the sums payable made more realistic.

(5) *Civil damages levy.* A lien should be imposed on civil damages awarded to patients treated in hospital following traffic and industrial accidents, the exact proportion to be a statutory part of the individual judgment or out-of-court settlement.

(6) *Promotion of national and local lotteries.*

(7) *Promotion of community appeals.* Local appeals for specific projects should be encouraged and could perhaps become a useful function of the new community health councils in collaboration with existing hospital leagues of friends.

There would be exemptions or abatements of charges for children, pensioners, the genuinely indigent, and long-term inpatients.

As Professor Illingworth emphasises, all supplementary money must be controlled locally, not consigned to the limbo of central exchequer. Whereas against a total annual NHS hospital allocation of £3437m,[3] supplements of tens or hundreds of millions might seem derisory, in the context of otherwise inescapable pruning of services even the smallest supplement becomes beautiful. Equally inportant is the prospect of fostering a resurgence of pride and energy in the hospital service.

P J E WILSON

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Swansea

[1] Wilson, P J E, *British Medical Journal*, 1974, **2**, 112.
[2] Central Statistics Office, *Facts in Focus*, 2nd edn. Harmondsworth, Penguin Books, 1975.
[3] Nairne, P, *Health Trends*, 1976, **8**, 61.

## Industrial action and the Royal Commission

SIR,—Although I entirely agree with the sentiments and suggestions contained in the Rev Dr W P Hedgcock's letter (13 November, p 1198), perhaps he has forgotten that the previous Royal Commission, not so long ago, set up arbitration in the form of the Review Body to take evidence from the profession and the Government periodically and to decide the proper pay for doctors in the light of the current economic situation.

I was younger then and breathed a sigh of relief, and I hoped to work in peace, accepting the Review Body's arbitration for better or for worse. But the Government didn't. It reserved the right to chop the arbitrated awards unilaterally. This it did on various excuses, such as economic situations (which the Review Body had already taken into account), and pay freezes (necessitated by industrial action of other groups who were not prepared to accept arbitration).

Although arbitration is the civilised answer, there is little point in going through the charade again. Past events have shown that governments of the day unilaterally reject the decision of a fair arbitrator when it is expedient for them to do so. Unfortunately until we are prepared to take firm industrial action *in defence* of an arbitrated award the process of arbitration will remain futile.

P R B PEDLOW

Hitchin, Herts

## Evidence to Royal Commission

SIR,—There can be little of greater significance to the future of British medicine than the evidence that the BMA will present to the Royal Commission. Many doctors will rightfully resign from membership if that evidence does not represent their views and because of that if nothing else there must be grass-roots consultation as never before.

I see little signs at present of anything other than the usual only partly representative machinery in action. The answers to a wide variety of questions must be sought by referendum—for example, Should patients pay their GP's directly, through insurances or not at all? Should the NHS be independent of Government? Should general practitioners dispense from their surgeries?

There are too many power-seekers and professional committee doctors to entrust the duty of presenting evidence to the Royal Commission simply to the standing committees and I call for intimate grass-roots consultation followed by a Special Representative Meeting. There must be no more cunning compromises or good deals for the present but a determined hard-line approach that will improve the plight of patients and the laughable level of doctors' remuneration.

ADRIAN ROGERS

Stratford-on-Avon,
Warwicks

**The BMA wrote to all divisional secretaries on 11 March inviting them "to consider whether you have any points you wish to put forward for inclusion in our evidence to the Royal Commission. . . . It would be helpful if you would include any facts or figures that you think would be relevant to the evidence." The General Medical Services Committee also invited local medical committees to submit their views and around 75% have done so. A Special Representative Meeting to discuss the evidence prepared by Council is planned for 9 March 1977.—ED, *BMJ*.

## NHS superannuation and war service

SIR,—In a letter dated 13 October 1976 (reference SD Letter (76)12) the DHSS are informing treasurers of regions and areas that the NHS Superannuation Scheme has a new facility whereby members may increase their contributing service by half of any period of war service, subject to the payment of additional contributions. The facility will be available to all persons who, having entered employment in the public health services in England and Wales, Scotland, Northern Ireland, or the Isle of Man after war service, become entitled to a benefit from the NHS Superannuation Scheme on or after 17 July 1975.

There is, however, a group of forgotten men who were denied the opportunity of war service, those who were reserved to serve the hospitals as senior residents and whose contribution was surely as great as those who served in the forces. These men freed their seniors to serve the forces; they undertook the responsibilities of consultants, commonly very soon after qualification, and in my view are equally entitled to the facility now being offered to those who enlisted.

Is the BMA or any other organisation making representation for these men to be offered this new facility?

WILLIAM H BOND

Birmingham

**The Secretary writes: "Full details of the new scheme for recognising war service appear on p 1337. There can be no negotiations on the extension of the scheme, to cover service other than whole-time service in HM Forces, during the current restrictions on improvements in pay and pension benefits (the proposals on war service were accepted in principle on 17 July 1975, just before the current restrictions came into force). The Compensation and Superannuation Committee will consider extension of the scheme when negotiations on further improvements can be made."—ED, *BMJ*.

SIR,—A short time ago (7 August, p 371) you kindly printed a letter from me about inequities in the recognition of war service towards NHS pensions. Only those who had the prescience to join the NHS before the magic date of 30 June 1950 qualify for this concession.

I have received letters from 30 doctors whose NHS service does not meet the criteria negotiated by the BMA for the war service pension concession. No doubt there are as many or more again from whom I have not heard, besides hundreds of non-medical members of the NHS, who are victims of this unfair arrangement. Only one of my correspondents sent a stamped envelope for a reply and so I should be grateful for the hospitality of your columns to thank the other 29 for writing to me. I would like to urge all those who have not already done so to write to their MP. MPs will probably be told by the Minister's dogsbody something like this.

"It is not unexpected that people who for one reason or another chose to work outside the NHS for a period after the war and failed to satisfy the 30 June 1950 date of entry requirement will feel that they are being treated unfairly. However, such claims are not really justified if it is remembered that the same criteria are being applied now as would have been applied had the facility been introduced soon after the war."

". . . The NHS (pension) scheme cannot now take on that liability."

"The NHS scheme has now made what, at this late date, is a very generous offer to those members who joined it on completion of war service. It is not surprising that many other schemes—for which I have no responsibility—have not done likewise and the NHS scheme certainly cannot do so on their behalf."

The fallacies in these quotations from letters to MPs are obvious. Most war service doctors left the services before the NHS was started, and if the facility had been announced in 1950

would undoubtedly have seriously considered switching to NHS employment. NHS pensions are not paid out of NHS funds and are not funded at all, but paid out of general Government revenue, from which source come the funds which pay the pensions of other public servants. The DHSS seems to take the view that pension recognition of war service has nothing to do with war service as such but is a sort of lucky dip which people ought to have known about a quarter of a century ago. Those who had the foresight to join the Colonial or other services instead of volunteering for the armed forces in 1939 have, of course, earned full pensions ever since. Most of my correspondents have, like me, spent their entire medical career in public services (the wrong ones of course) including the Army and Navy, State-financed medical schools, the Ministry of Pensions, HM Overseas Service, and the United Nations Organisation. There were also two who became medical students after demobilisation and were, of course, unable to qualify before the magic date. Had they become laboratory technicians they would probably have got better pensions.

One letter was from the widow of a doctor who would have had his war service recognised for pension had he lived until 17 July 1975 (another magic date) but died too soon, to his widow's detriment.

It must be admitted that this is not an auspicious time for any section of the hated public service to press for improved pension conditions, but no time is ever auspicious. May I ask that the BMA should get together with all the employee organisations which represent sections of the public service enjoying war service pension entitlement and try and sort out with the Government the inequities to which I have drawn attention. There may be as many as 100 doctors involved but they are only the tip of an iceberg composed of equally deserving non-medical NHS employees, civil servants, and teachers. A combined approach might be worth a trial.

One of my correspondents told me that whereas teachers get a whole year's pension for every year in the forces, NHS employees get only six months. If this be the case it suggests that even more wool was pulled over our representatives' eyes by the DHSS than we had realised.

MARK HUGHES

Newton Abbot, Devon

**The Secretary writes: "With reference to Dr Hughes's third paragraph, there is a NHS Superannuation Fund, on paper anyway, from which benefits are paid. The two correspondents who entered medical school after war service will qualify for recognition of their war service if they meet the criteria laid down in para 1(*b*) of the note on p 1337.

"The information to which he refers in his last paragraph is incorrect. The Teachers' Superannuation (War Service) Regulations 1975 (SI 1975 No 276) state (regulation 2) that war service will count at half its length in calculating the benefits and transfer values payable under the teachers' Superannuation Scheme. The conditions for recognising war service in the NHS Superannuation Scheme (including the cut-off date of 30 June 1950 except for those in training) are similar to those laid down in the above regulations.

"The war service arrangements as they now stand give rise to many anomalies, which will be considered by the BMA Superannuation Committee, and no doubt also by the Joint Superannuation Consultative Committee, on which the BMA is represented and which represents all staff interests in the NHS, when the present restrictions on improvements in pension benefits cease to apply."—ED, *BMJ*.

### The £8500 limit

SIR,—I have just received a letter which informs me that whole-time consultants whose salary at 1 April 1976 was £8322 may seek a supplement to increase total salary to £8500. This supplement of £178 pa, however, will be reduced by an amount equal to the sum earned from public sources for lectures, domiciliary consultations, category II work, etc.

It is clear, therefore, that those consultants who contribute their time and their skills to provide postgraduate and undergraduate teaching and additional services are to be penalised. Those consultants, however, who do not undertake additional duties will have their salary increased to the same level without being subjected to the inconvenience of doing any additional work. Comment would be superfluous.

DAVID EVERED

Endocrine Unit,
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## Points from Letters

### Metoclopramide and prolactin

Dr K D JONES (Welsh National School of Medicine Cardiff) writes: Dr A S McNeilly and others (29 June 1974 p 729) reported that a single 10-mg dose of metoclopramide was capable of causing a 3- to 8-fold increase in the serum level of prolactin. They stated that "longterm administration of metoclopramide has occasionally been associated with galactorrhoea." I recently saw a 30-year-old woman who developed galactorrhoea after taking the drug for only three days. It had been prescribed for gastroenteritis in a dose of 10 mg 6-hourly. . . . Unfortunately I am not able to furnish any information on the serum level of prolactin in this patient. Lactation ceased promptly on withdrawal of the drug. . . .

### Postmenopausal urinary symptoms and hormonal replacement therapy

Dr D FREEDMAN (Jakobsbergs Sjukhus, Järfälla, Sweden) writes: In answer to Mr P J B Smith (16 October, p 941) . . . the hormone I have used exclusively for the treatment of senile urethritis is a 50-mg intramuscular depot injection of oestriol phosphate given at monthly intervals for three months. In Sweden this is marketed by Leo Drugs Ltd as Triodurin. It is perhaps unwise to give this treatment to patients who have previously been treated for cancer of the uterus, ovaries, or breasts, and is contraindicated in severe liver damage and thromboembolic disease. . . . In my own series 33 postmenopausal women presenting with symptoms of urethritis had a mean age of 56 years (range 42-72). Routine examination, cystoscopy, exfoliative cytology, and a gynaecological examination were performed on all 33. One patient was found to have a bladder carcinoma, one a postirradiation trigonitis, and one a urethral stricture. Of the remaining 30 . . . 18 received a full course of oestriol treatment. Additional chemotherapy was given when indicated (three patients). On follow-up 15 patients were totally free from symptoms and delighted with the results. Three of them subsequently had a further course for recurrent symptoms after some 12 months and one patient has recently completed her third course, all with excellent results. Three patients did not consider the hormone injections to have alleviated their symptoms. . .

### Ankylosing vertebral hyperostosis: unusual presentation

Dr JENNIFER M HUNTER (Spital, Wirral, Merseyside) writes: I would like to sound a note of caution after reading your leading article on ankylosing vertebral hyperostosis with interest (6 November, p 1091). My only experience of this condition presented in a manner which you did not mention. Recently I was asked to anaesthetise a 74-year-old man . . . who denied any limitation of his physical activities. After intravenous induction of anaesthesia with thiopentone 250 mg and suxamethonium 50 mg and inflation of his chest with oxygen . . . I was able to open his jaw without difficulty but was completely unable to flex his neck. Hence visualisation of his vocal cords by direct laryngoscopy was impossible. . . . Eventually I was able to perform blind nasal intubation but only with considerable difficulty, as I was unable to encourage final movement of the endotracheal tube through his vocal cords by extension of the neck. . . . Postoperative *x*-rays showed a continuous sheet of bone fusing the anterior aspect of all his cervical vertebral bodies. . . .

### Postcoital contraception

Mrs ISHBEL M MONKS (Chelsea Hospital for Women, London SW3) writes: It is surprising that your leading article (23 October, p 961) should describe the postcoital use of an IUCD as abortifacient. However such devices work, it is now accepted that the action is anticonceptual. Even if one is inserted after conception, there is no evidence that early abortion may be precipitated by disruption of the trophoblast. In practice, a normally implanted pregnancy may survive a good deal of trauma including dilatation and curettage or suction termination. The postcoital action of a device . . . depends on inserting it within 3 or 4 days of coitus so that a hostile environment is provided in the uterus before a blastocyst could reach the cavity. This is clearly still a contraceptive mechanism. . . .

### Carcinoma of vulva in twin sisters

Mr A K GHOSH (Watford General Hospital, Herts) writes: I read with interest the recent reports of Mr S Bender (28 February, p 502) and Mr S A Way (3 April, p 834) regarding carcinoma-in-situ of the cervix in sisters. I wish to report carcinoma of the vulva occurring in two sisters. . . . They were identical twins and both of them were diabetic. It is probable that the diabetes mellitus in these cases caused diabetic vulvitis and chronic epithelial dystrophies which eventually led to invasive carcinoma.