pleasant land" England would be with, say, 20 million inhabitants. Each birth in the United Kingdom leads to about 40 times as much damage to the planet as a birth in a less developed country. And many of the one in four births now occurring outside marriage can hardly be explained away as planned births in common law relationships.

Hence "greening the NHS" surely means more training, more research to improve the presently far from perfect contraceptive methods, and maintenance within the service of choice (that is, by providing clinics as well as and complementary to general practitioner services) for women and their partners.

Instead, during the past five years most health authorities have cut or have considered cutting their district run family planning clinics. The Margaret Pyke Centre was caught in this process. In 1988 the annual budget was cut by £120 000—one seventh of the total—and this year further mutilation was proposed. Fortunately, the national outcry (including nearly 4000 signed communications from British doctors) has led to the centre being considered a special case, with bridging finance from the Department of Health and the promise of a long term solution largely outside the budget of Bloomsbury District Health Authority. As medical director I thank all *BMJ* readers who have helped towards this satisfactory outcome.

There is more to be done, however, both within and outside the NHS—that is, supporting the Family Planning Association in protecting other local authority supported clinics nationwide and taking every opportunity (perhaps by joining Doctors and Overpopulation) to promote birth control as vital for the future of the world and as a human right.

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1 Gray M, Keeble B. Greening the NHS. *Br Med J* 1989;**299**:4-5. (1 July.)

Prolonged vitamin D deficiency and autonomous hyperparathyroidism

SIR,—Dr A H Sultan and colleagues described two Asian women with autonomous hyperparathyroidism after prolonged vitamin D deficiency.[1] Unfortunately they did not measure serum parathyroid hormone concentrations either at the time of diagnosis of osteomalacia or after parathyroidectomy.

Showing hypercalcaemia and inappropriately high concentrations of parathyroid hormone is cardinal to the diagnosis of tertiary hyperparathyroidism after the removal of parathyroid adenoma as the remaining three parathyroid glands should be hyperplastic. Case 2 seems to fit in with this as hypercalcaemia persisted after parathyroidectomy. In case 1, however, calcium concentration became normal after the removal of parathyroid adenoma. This patient should have been diagnosed as having concomitant primary hyperparathyroidism and vitamin D deficiency with nutritional osteomalacia.

Although we have seen at least two cases of primary hyperparathyroidism with concomitant parathyroid adenoma and nutritional osteomalacia, we have not seen true tertiary hyperparathyroidism with a parathyroid adenoma. It is therefore unfortunate that postoperative data on parathyroid hormone concentrations are not available in case 2. Measuring parathyroid hormone concentrations is also important in such patients as calcium concentrations are often normal and a combination of low 25-hydroxyvitamin D concentrations and raised parathyroid hormone concentrations often may confirm the diagnosis of osteomalacia related to vitamin D deficiency.[2] In fact we prefer this combination of tests to a bone biopsy; the combination also allows sequential tests if necessary.

We agree that patients with osteomalacia treated with vitamin D supplements should be followed up for protracted periods not only because they may rarely have masked primary or tertiary hyperparathyroidism but also because they may falter in taking long term medication after their symptoms have subsided. We have seen several patients with recurrent osteomalacia who had been treated previously in our own and other centres.

Other important conditions in which prolonged vitamin D deficiency is associated with hyperparathyroidism that is not suppressed after adequate vitamin D supplementation are chronic renal disease (as pointed out by Dr Sultan and colleagues) and chronic liver disease, especially primary biliary cirrhosis.[3] It is important to monitor parathyroid hormone concentrations in patients with these conditions and with nutritional osteomalacia as the conditions are associated with osteopenia. Bone density is inversely related to serum parathyroid hormone concentrations,[4] and severe osteomalacia with osteopenia may result in pathological fractures.[5]

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Use of stents for treating obstruction of urinary outflow

SIR,—The letter of Dr K Moretti[1] raises several points that should be addressed. With respect to our selection of patients for insertion of prostatic stents,[2] all but one of these patients were recruited over a four month period from hospitals throughout the south east of England and not from the Hammersmith catchment area. The duration of catheterisation ranged from two weeks to three years, reflecting how long these patients had endured their complaint and that transurethral resection had not been offered before they were considered for stent insertion. Details such as these were omitted from the article for the sake of brevity.

Three of these patients had three major risk factors for prostatic surgery, two had two risk factors, and four had one risk factor that, in the view of the referring clinicians, made them unsuitable or unfit for surgery. Three of these original patients have died (one from his progressive carcinoma of the bronchus, one from a stroke, and one from a diverticular perforation that was managed conservatively in view of his poor general condition).

Mortality from prostatectomy has declined greatly over the past three decades,[3] but what is often overlooked is what happens to these patients after their return home. Malone *et al* observed that for patients with acute retention there was a mortality three times that expected for age matched controls in the first year after surgery.[4] The fact that three of our patients died (of unrelated medical conditions) within the first four months after the procedure illustrates that for these high risk, frail patients there is a need for a quick and easily performed procedure to allow them to pass urine spontaneously and then return home. It is in this group of patients that these stents may offer the most.

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Junior doctors' rotas: a pyrrhic victory

SIR,—Before resting on its laurels the BMA Junior Hospital Staff Committee must consider the cost of its "successfully" fought working hours campaign, which has resulted, by ministerial edict, in the summary abolition of all one in two rotas.

The replacement of one in two rotas by one in three rotas or better is to be achieved not by a matched increase in manpower but simply by rearrangement of rotas and cross cover arrangements both within and without the various disciplines. A one in two rota which converts to a one in three rota will simply result in the doctors concerned covering some 33% more patients on call than previously. In many instances this will stretch doctors to the limits of their physical capabilities. More importantly, it may well push them beyond the bounds of safe clinical practice. We, the "beneficiaries" of the recent campaign, can now expect to work considerably harder, albeit less often, for less money while our hospital treasurers count the financial savings which our representatives so militantly and flamboyantly fought for. Have we not simply shot ourselves in the foot?

What of the less onerous non-resident second and third on call one in two rotas which are commonly worked by registrars and senior registrars? I work such a rota and I resent the fact that now I have no choice but to reduce to a one in three rota, in doing so losing over £4000 a year. The unconditional abolition of one in two rotas makes no distinction between rotas which are known to be onerous and those similar to my own that are less onerous and non-resident. Ironically a relatively recent review of junior hospital doctor rotas within my own hospital, by a panel on which junior doctors were satisfactorily represented, concluded that many of the non-resident one in two rotas of registrars and senior registrars were non-onerous and, reflecting the satisfaction of their incumbents, did not require revision. Those constructively derived recommendations are now to be ignored.

Within the Mersey region a frantic hotchpotch of rota rearrangements is being hurriedly spliced together to comply with the edict. Consideration is being given not only to cross discipline cover but even to cross hospital cover. Some senior house officers on call will now cover 100 patients instead

of a maximum of 56. Their resultant salary cuts will not be used to increase manpower because limits have already been set; instead working conditions are to be made even more deplorable.

A militant group of junior hospital doctors, many of whom will spend a mere two to three years in hospital medicine, all too vocally campaigned for these unconditional settlement terms. Inexperienced, fresh from medical school, and possibly destined for non-hospital careers, their blinkered militance and short term career aspirations have blinded them in their consideration of their less vocal, more senior colleagues, many of whom are destined to spend 10 or more years in junior hospital posts. For them they have effectively negotiated a 20% salary cut while for themselves they have earned a welcome reduction in what I accept were unacceptably arduous rotas.

Before the dictat is finally implemented an urgent revision of all one in two rotas must be undertaken. A distinction must be made between resident and non-resident rotas. Doubtless the minister will resist any move which will result in the loss of new found revenue. The committee must return to the negotiating table to protect the interests of those who innocently suffered as a result of their impetuous campaign. Reinstatement of selected rotas cannot be decided at regional level. Ministerial approval is called for. That approval will be forthcoming only if the committee moves swiftly before the infrastructure is dismembered.

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General practitioners' referrals

SIR,—The articles by Ms Angela Coulter and her colleagues are timely in view of the fact that we must soon make contracts with hospitals to which we refer patients.[1]

I looked at referrals in our practice of 13 000 patients. Within three months in 1989 we made 564 referrals, 52 of them outside the district. We used 25 hospitals outside our district, many of them in London, where we were seeking specialist opinions. Nevertheless, referrals from general practice underestimate the number of attenders at outpatient clinics because they exclude tertiary referrals and patients attending hospital for follow up. For example, in July we referred patients to eight hospitals outside our district but we had incoming letters from 20. Data about referral patterns certainly could be collected by general practitioners, but there would be an element of inaccuracy as incoming letters do not correlate with the number of outpatient attendances, since hospitals may not write a letter or they may write more than one letter for one outpatient attendance if tests have been carried out. If hospitals collected their data about referrals they could identify general practitioners by using the general practitioners' NHS number.

If health authorities and practices with budgets are to arrange contracts by 1 April 1991 they probably need six months to do so. But they also need accurate information and that can be obtained only by surveying all outpatient and inpatient attendances in the whole NHS from 1 October 1989 to 30 September 1990. This does not seem likely to happen, but if the information is not collected the contracts made will not reflect current referral patterns.

I can understand the need for an internal market and for targets, but I suspect that the secretary of state did not realise the complexity of referral patterns when he thought of general practitioners contracting for services.

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NHS review

SIR,—Rumours abound of plans for general practitioners to introduce sanctions[1] as if we were borrowing a programme of action from anti-apartheid campaigners. They won't work, so what do we do?

Doctors must persuade the public that there is a better way to improve the health service and not just rail against the government's ideas. We must produce an alternative medical manifesto. The following suggestions come from an alternative medical manifesto drawn up by the 60 doctors of the Fareham Medical Society and emphasise what we want to help improve our service:

- The ability to offer longer appointment times, to give more time to patients so their health screening needs can be addressed as well as their illnesses—which means more doctors and smaller lists
- The right to prescribe without financial restraint coming between the doctor, the patient, and the most appropriate treatment while recognising the need for economic and rational use of the formulary
- The right of the general practitioner to refer patients to the hospital and consultant of his or her choice, and to demand specifically stated maximum limits for waiting times for appointments and subsequent procedures in all specialties
- Increased pressure from the government to encourage a high uptake of vaccinations and immunisations instead of trying to bribe general practitioners into forcing patients to comply
- A statutory limit on doctors' hours of continuous work
- Coordinated technology to allow general practitioners to communicate directly with family practitioner committees, hospitals, laboratories, and *x* ray and outpatient departments. This would improve efficiency far more than dedicating such technology to administrative and management roles.

How are we to achieve all this? We must reemphasise that we are near the bottom of the league in the percentage of the gross national product that Britain spends on health care and dismiss government bleating about how much it has increased NHS funding, which has not been enough. And the method? More item of service fees, which are a good, well proved incentive that will not need new, untried administrative and management structures.

The BMA should spend some of its advertising campaign money on promoting constructive proposals: a general practitioners' medical manifesto is the answer. Public support will be overwhelming. Mr Clarke will have to listen as he knows this issue might cost his party the next election.

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Twenty four hour care in inner cities

SIR,—We welcome the paper by Dr A E Livingstone and colleagues on the high out of hours workload in general practices in deprived areas.[1] Their findings mirror our own in a detailed audit of our practice's out of hours workload from April 1984 to April 1985, and we strongly endorse their conclusions.

We practise in a large postwar peripheral council estate in a health centre with 7800 patients. Bristol City Council surveys identify the area as one of the two most deprived in Bristol. In our audit the total number of patient contacts, between 7 pm and 7 am on weekdays and 12 noon on Saturday to 7 am on Monday were 1635. Of these, 347 were between 11 pm and 7 am (44·5/1000 patients/year) and telephone advice resolved only 308 (18·9%); 1326 (81·1%) were visited, often because the extent of patient deprivation leads to inadequate telephone communication.

We link our high out of hours contact rate, particularly that from 11 pm to 7 am, closely to the extent of deprivation in families with children under 5 years. Children under 5 make up 10·8% of our list (the national average is 8%). In 66% of these families the major wage earner is unemployed; in 70% one or both parents are under 21; 48·5% are single parent families (often living in high rise blocks); and 30% receive support from social workers, probation officers, or the National Society for the Prevention of Cruelty to Children.

The high out of hours workload is mirrored in our daytime workload, which is linked to the higher morbidity levels of socially deprived communities. To give high quality medical care in deprived areas, where the medical and social morbidity is higher, we need much smaller than average list sizes, and our doctor to patient ratio is 1:1560 (national average is 1:2020). The implications for income are self evident, and the failure of the current system of remuneration to reflect workload, which depends on medical and social morbidity levels, concerns us. We expect the 1990 contract to worsen the situation. We are concerned that the Jarman index gives a comparatively low weighting to the "forgotten areas of deprivation"—the large peripheral council estates, where unemployment, morbidity, mortality, and numbers of preschool children are high.

We would like to make a cri de coeur on behalf of deprived patients and the health professionals serving them. The system needs to recognise that those most in need of health care are those who get sickest and those who are least able to help themselves. And the carers need the resources to do the job.

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Tunga penetrans: the tale of a physician

SIR,—Although we agree with Dr Janet McLelland and colleagues that tungiasis may become commoner as more people travel to the tropics,[1] we are concerned by their suggestion that its treatment is merely a matter of excising the flea and her eggs. Tetanus is a recognised complication of this condition,[2] and patients must be fully immunised against it.

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