They have not dealt with my most important criticism, that in considering the significance of such differences they did not take into account the very different duration of observation in the two groups. I would kindly suggest that they should recalculate their data (after excluding those with cancer at entry) and present the risk in two groups based on patient-years of observation. That would get us nearer to reality. If there is then an important difference I shall hasten to agree that they may have a point.

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Oral contraceptives and premenstrual tension

SIR,—I find both the answer in "Any Questions?" (27 September, p 761) and the letter from Dr Eleanor Mears (15 November, p 408) extremely confusing. I should be most interested to know what scientific evidence exists for either a high- or low-dose or a predominantly progestogenic or oestrogenic oral contraceptive being most suitable for women suffering from premenstrual tension. My own experience suggests no such easy answer.

The classical description of the premenstrual syndrome¹ includes headache, migraine, epilepsy, nervous tension, depression leading to broken homes, weight gain, abdominal distension, sinusitis, allergic rhinitis, asthma, sciatica, and fluid retention. Large increases in most of these conditions have been found among oral contraceptive users, but only a small decrease in premenstrual tension has been noted.²

Surely the fallacy is to relate the premenstrual syndrome to hormone balance exclusively? In fact it tends to be the same women who have the most severe and varied side effects to different doses and combinations of oestrogen and progestogen, while the least reactive woman can tolerate any pill for several years before developing side effects. Using steroids, whether oestrogens, progesterone, progestogens, or prednisone, for the premenstrual syndrome may be temporarily suppressing an immunological reaction rather than correcting a hormonal imbalance.³

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¹ Greene, R. and Dalton, K., *Proceedings of the Royal Society of Medicine*, 1955, **48**, 337.

² Royal College of General Practitioners, *Oral Contraceptives and Health*. London, Pitman Medical, 1974.

³ Grant, E C G, *Hemicrania*, 1975, **6**, 2.

Sight in newborn babies

SIR,—As always, the Health Education Council is most grateful for constructive criticism of the kind that appeared in Dr R Davie's letter (1 November, p 286), about our pamphlet on keeping newborn babies warm. Our error will, of course, be corrected as soon as possible.

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Changing status of doctors

SIR,—The changing status of doctors has been debated widely during recent years. Now Dr P Kekki has contributed to the debate with his article on "Changing status of doctors in Finland" (1 November, p 273). We wish to continue this debate, but first we would like to correct some of the obvious faults in the article.

Firstly, contracts for jobs in health centres in Finland are permanent, but one of the permanent doctors is elected to act as the responsible doctor (principal) for four years. Secondly, the Community Health Care Act 1972 did not create the post of treasurer. Thirdly, the method of payment was the result of collective bargaining, in which the Finnish Medical Association played the main role and approved the pay system. Fourthly, the length of university training for doctors is six years (not 4½ years as stated in the article); after this academic period training continues in health centres or hospitals for one year. Fifthly, the proposed Bill on hospital care does not suggest that doctors in charge of hospitals should hold their positions for fixed periods.

Although it is described as a "short sociological study" in the summary, Dr Kekki's article does not focus on the responsibility of the medical profession to the health services and public health in the interests of people and society. It is more concerned with the falling prestige of the profession in consequence of a weakening status of doctors. We longed for some discussion about other factors which can have important impacts on the relationships between the doctors and the decision-makers at all levels.

In Western societies the costs of health services are approaching the upper limit which it is held justifiable to spend on health services. This is even more significant when one does not always have enough knowledge of the benefits which would be gained by increasing costs. Dr Kekki does not relate the significance of this development to legislation and plans which try to guarantee health services for people at a reasonable cost. The doctor's role as an administrator has been challenged by other professions and politicians. The sovereign role of the medical profession to guide money streams is becoming questionable. This sociological explanation might have some impact on the changing status of the doctors.

Increasing knowledge of health by laymen and increasing political interest in health matters among people and politicians are, as Dr Kekki states, "some of the main reasons for the current trend." People and politicians have noticed that the development of health services concerns not only the medical profession but also people as consumers and tax- or insurance-payers. Hence it is essential that they should act together with the medical profession to develop the health services. Perhaps doctors should be relieved that other people will take part in large-scale economic decisions in the health services and share responsibility for them.

If Dr Kekki had included these viewpoints in his study of the changing status of doctors in Finland he perhaps would have argued in a different way and might have drawn different conclusions.

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Patient care under the NHS

SIR,—Professor P R Rickham (15 November, p 393) must have listened to entirely one-sided reports to make assertions about "the disastrous effects on overall patient care brought about by the British National Health Service." Nothing could be farther from the truth, as those who practised medicine before the war well know.

The NHS provides not only a very much better service for the population as a whole than anything we had before, but also facilities for doctors and others to practise their professions that have been a vital factor in the development of British medicine to its present high level.

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Salary increments and anti-inflation policy

SIR,—With Mr J M Shennan (25 October, p 229) and many others I was both surprised and disappointed to find that the consultant incremental scale, which is closely linked to the career structure, should have been interfered with by the Government's counter-inflation measures. This represents a breach of faith or, worse, a breach of contract.

It does seem very possible, however, that there could be some relaxation as far as the second increment is concerned. Many whole-time consultants on the first incremental point do not engage in domiciliary work and receive no significant additional payments from the NHS.

I am advised that pressure should be brought to bear by those concerned on area health authorities and the Department of Health and Social Security as there is a virtually unanswerable case—even allowing for the strictest interpretation of the Government's guide lines.

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* * The Secretary writes: "The Staff Side of the Joint Negotiating Committee for Hospital Medical and Dental Staffs is pursuing with the Department of Health the possibility of consultants on the second point of the incremental scale being allowed a partial increment to bring them up to £8500, the limit imposed by the Government's anti-inflation measures."—ED, *BMJ*.

Superannuation: FSSU parallel arrangements

SIR,—It is agreed that a great deal of thought has gone into improving superannuation under the NHS scheme and this is very laudable.

The plight of those who remained in the Federated Superannuation Scheme for Universities (FSSU) following the introduction of the NHS in 1958 and were employed in posts in the NHS is far from satisfactory. I have attempted to change to the NHS scheme over a period of many years but unfortunately this is not possible. The FSSU in 1948, as I understood it, was identical with the university scheme, but a change to "parallel arrangements" was made soon after 1948. According to a letter received from the Under-Secretary of State for Scotland, an option was given in 1950 to change to the NHS scheme, but on making inquiries from the regional hospital board to which