graduate training. Furthermore, doctors often continue to work or are re-employed in the service after the customary retiring age of 65, and so are hit by the pensions abatement rule. There is also the problem of non-recognition of doctors' pre-1948 service.

The abortive Crossman pension proposals prompted widespread discussion about the effectiveness of state pensions, and of the wide variety and scope of other schemes. This was all to the good. There are about 65,000 private occupational schemes in Britain at present, and doctors who compare pensions of senior staff in the private sector with their own prospects on retirement may wonder whether they have a good bargain. In 1969 the Prices and Incomes Board examined the salaries and pension rights of directors and senior executives in a sample of private sector companies of varying size when it was studying top salaries in the private sector and nationalized industries. The Board described nationalized industry schemes—which are broadly similar to the N.H.S. scheme—as in some respects comparing unfavourably with the private sector, especially for employees unable to complete 40 years of service by retirement age. Contributory schemes in the private sector had comparable employees contributing between 1 and 4-6% of their salaries—the N.H.S. employees' contribution is 6%. Private sector employers, unlike the public sector, more often took advantage of the Inland Revenue rule allowing a pension of two-thirds final salary for shorter periods of employment than 40 years. The report also commented... failure to make use of the permissible limits [of the two-thirds rule] could, we consider, force the Government to make higher arrangements in terms of absolute pay...

Levels of pay and of pensions cannot be divorced, and this observation by the P.I.B. reinforces the B.M.A.'s view that superannuation should be taken into the remit of the profession's new Review Body, as is to be the case with M.P.s, whose pay is to be looked at by the parallel Review Body set up for judges, senior civil servants, and heads of nationalized boards. So far the Government has not accepted this proposal. The profession's long-standing differences with the Government over superannuation, and in particular repayment of compensation for loss of practice goodwill, has soured the views of many senior doctors towards the N.H.S. unnecessarily. Handing over pensions to the Review Body for study will not immediately solve the problem but it should certainly reduce the area of friction between Government and profession.

Before the N.H.S. the "goodwill" value of a family doctor's practice provided some security for his retirement. Thus those doctors who had practised before 1948 and then joined the N.H.S. were at least partly dependent on the amount of practice compensation due from the Government to make up for the lack of pension in respect of their early professional career. This situation has contributed to the difficult financial position which has faced many general practitioners who have reached retiring age since 1948, and the number of doctors staying on in practice until aged 70 or beyond has probably been influenced by this. The "goodwill" compensation fund—a result of hard bargaining with Aneurin Bevan—has been seriously devalued by inflation and the interest rate on it of 21% is pitiful beside current interest rates. The fund still owes over £9m. to just under 4,000 doctors. In the context of the N.H.S. annual budget this is not a large sum, and the A.R.M. in 1970 once again called for the Government to repay the money still owing to family doctors.

The B.M.A. is seeking a separate, funded scheme for doctors in the N.H.S., a pension at 60 of two-thirds final pay (with provisions to cover general practitioners, whose earnings tend to fall towards retirement), improved disability pension for early retirement on grounds of ill-health, and abolition of the rule which reduces a pension if a retired doctor returns to work in a public sector. Reasonable pensions for widows and receipt of pension benefit, as from 1948 in the voluntary hospitals and national insurance scheme are also sought. These are moderate and responsible objectives.

The Department of Health has listened to doctors' criticisms of their superannuation scheme many times in recent years and resolutions on the subject appear regularly on the agenda of the A.R.M. Inflation is acute, doctors of all age groups are seriously concerned over their superannuation, and pensions are becoming a major bargaining area between employers and employees in all sectors. If pay was a major issue for the new Review Body in the sixties then pensions may well be so in the seventies.

Aortic Aneurysms

Trainee surgeons are sometimes told that "it takes two years to learn how to do an operation, five years to learn when to do it, but a lifetime to learn when not to do it." In fact it may take more than one man's lifetime for acceptable evidence to accumulate on which to base a critical analysis of the value of a new procedure. The first replacement of an aneurysmal aorta by a cloth prosthesis was performed by C. M. DuBois in 1951, and there has been a hot-worded controversy ever since about this form of treatment.

There is no argument about the patient with a leaking or enlarging aneurysm, for these patients will certainly die in the immediate or near future if they are not treated, and operation is the only form of treatment that is effective. The mortality rate of the operation may be very high if the aneurysm has ruptured, but anything less than 100%—the natural history—is worthwhile. The patient with a symptomless aneurysm poses more problems. He is bound to have other degenerative vascular disease; but though the chances of him dying in the foreseeable future from a coronary or cerebral thrombosis are high, the chances of him dying from rupture of his aneurysm are higher. Overall he has only a 20% chance of surviving five years. D. E. Szilagyi and his colleagues reviewed 480 treated and 223 untreated aneurysms (though not completely comparable groups) and found that surgical replacement of the aneurysm approximately doubled the patient's life expectancy. Their patients with untreated small aneurysms, less than 6 cm, had a longer life expectancy than those with large aneurysms, but even so the risk of rupture (15-20%) was higher than the mortality rate of resection (2-3%). They concluded that all aneurysms should be treated surgically. Reports of the natural history of aneurysms in some of the earlier studies do not entirely agree with these findings, but most of the older papers have severe deficiencies in the methods of diagnosis and the
determination of the cause of death. The value of the studies published in the last decade lies in the accuracy of diagnosis and in the statistical care with which the death rates have been computed and compared—the latter being the more difficult problem as we are dealing with an abnormal population with a generalized disease.

So all aneurysms should be treated surgically, provided the general state of the patient permits it. What is the mortality rate of elective aneurysmectomy? The figures from the large centres show a declining rate, from 10% in the early years to less than 5% now. This is the result of increasing technical expertise and improved postoperative care, and it argues strongly for the treatment of all aneurysms in specialized units. This is no problem in the United Kingdom, where all patients are within reach of a vascular surgeon. The difficult case for the general surgeon is the patient with an aneurysm that suddenly becomes very painful and is probably beginning to leak. Surgery is urgently required; but should it be done locally with a higher morbidity and mortality or should the patient be transferred to a specialist? If the patient has no physical signs of blood loss then he should be able to withstand a journey of an hour or so, but if he is hypotensive the aneurysm is likely to be ruptured, and it is better to operate on the spot even though his general condition improves with blood replacement. Provided an adequate incision is made and there is ample blood replacement at hand this need not be as hair-raising an operation as many expect. Almost all abdominal aneurysms start below the renal arteries and the only urgent part of the operation is the application of a clamp across the aorta below the renal arteries. Once this is done the surgeon can relax and proceed as in an elective operation.


Marriage and Arthritis

All types of active arthritis cause pain, stiffness, and dysfunction, and they impose considerable limitations on the daily life of the sufferer. Attention has been given to the effects of arthritis on life in the home, office, workroom, and on the factory floor, and adaptations to dining rooms, bathrooms, kitchens, and lavatories described in detail to help the patient in his daily activities. But little notice seems to have been taken of the effects of arthritis on the patient’s sexual activities and his or her ability, or inability in many cases, to lead a full and normal married life.

Inability to lead a normal sex life may mar or break some marriages, and in histories of patients with rheumatoid arthritis it is not unusual to hear of the unaffected party’s resorting to alcohol or to other extramarital interests. Broken homes are not unusual in such situations. The disease itself may undergo periods of relapse triggered off by marital separations and differences, sometimes by true exacerbation of the pathological process. The patient may also experience a drop in the pain threshold and the onset of mental depression, with consequent failure to continue the fight against what appear then to be overwhelming odds. It is therefore timely that an inquiry into this previously almost unmentioned and unmentioned subject has been published by H. L. F. Currey from the London and Notley Hospitals.

This study is confined to patients with osteoarthrosis of the hip, a group of sufferers who because of their age and absence of systemic features might have been expected to be less affected than patients with rheumatoid arthritis. A questionnaire was sent to 235 married patients. Of the 121 patients whose replies were analysed 73 were women, 48 men. All were under 60 years of age, and all had undergone surgical treatment of one or both hips in the previous 10 years at either the London or the Notley Hospital. They were therefore a selected group of patients with one particular type of arthritis, and all had been treated surgically.

The results are of interest, though perhaps not unexpected. Of these 121 patients 81 (67%) reported some degree of sexual difficulty because of their arthritis and nine discontinued sexual intercourse because of it. Sexual difficulties were more common and more severe in the women than the men, these difficulties being due usually to pain and stiffness in the hips rather than to any loss of libido. Only a minority, one-quarter of these patients, recognized the arthritis as a distinct cause of unhappiness and mental tension, the frequency of marital problems being in proportion to the degree of sexual difficulty. In 70 patients the results of surgical operation on the hip could be analysed in relation to sexual difficulties, the operations performed being arthroplasty (35), osteotomy (16), total replacement (9), arthrodesis (5), Girdlestone arthroplasty (3), and femoral head replacement (2). The improvement in general symptoms was greater than was relief of sexual difficulties, though these, too, occasionally improved dramatically. The number of operations performed was too small to allow proper comparison between the different methods employed, but total replacement appeared to give best results in relieving pain and sexual difficulties. In contrast arthrodeses, while relieving pain in the hip, tended to have a bad effect on sexual function, and in two cases ended the sexual relationship.

Two-thirds of the patients with sexual difficulties welcomed some form of advice, usually for their partner as well as for themselves. Most favoured a booklet on the subject in preference to an interview with the family doctor or with a medical social worker, but one-third of patients with sexual problems ascribed to arthritis were not in favour of any form of advice on the subject. It seems that some patients are embarrassed or offended by being offered advice in these matters. Some, however, would have welcomed more exact advice from the surgeon on when it would be safe to resume sexual relationships after operation, some women in particular being frightened of damaging the operated joint. It is clear that this is a neglected subject, largely because, though of vital importance to the arthritic patient and his or her spouse, doctors, physiotherapists, and nurses are reticent about discussing such personal matters with the patient and the patient with them. Booklets have been written on “Your arthritis and your garden”, but not yet on “Your arthritis and your marriage.” This article seems to be the first step in that direction.