patients, associated with any evidence of drug-induced lupus.

It is possible therefore that extension of Dr Marshall's investigation to larger numbers of patients, with appropriate age-matched controls, could result in conclusions different from those reported. However, their finding that all prazosin-related ANF patterns were of the speckled variety is very unusual. When ANF did occur in patients on prazosin in our study it was not restricted to this morphological pattern. This suggests that there may be some unusual factors influencing results in Dr Marshall's patients.

The full data from which this summary is drawn will be presented elsewhere.

J D WILSON
R J BOOTH
J Y BULLOCK

Department of Medicine,
University of Auckland School of Medicine,
Auckland, New Zealand

¹ Wilson, J D, *et al*, *British Medical Journal*, 1978, 1, 14.

Treatment and survival in advanced breast cancer

SIR,—Dr T Priestman and his colleagues have reported the results of a comparative trial of endocrine versus cytotoxic treatment in advanced breast cancer (16 December, p 1673; 14 May 1977, p 1248). In their trial they administered oestrogen to postmenopausal patients with lung metastases and prednisone to postmenopausal patients with spread to liver or lymphangitis carcinomatosa and compared the therapeutic results with those of cytotoxic agents. In cases of extensive visceral involvement (the authors do not report details about the extension of metastases) the patients are at immediate risk. In these cases we believe it is not justifiable to treat them with oestrogens or only steroids (no matter what kind of trial they did) when it is well known that it takes at least three to four weeks for a hormonal response, whereas an immediate therapeutic response is needed. The treatment of choice is an intensive chemotherapeutic combination (including steroids).

S C TSILIAIOS
A E ATHANASIOU

Oncology Outpatient Clinic,
Idrima Kinonikon Asfaliseon,
Athens, Greece

Synovial biopsy in arthritis

SIR,—I was interested to read your leading article (10 February, p 363) on "Synovial biopsy in arthritis." I was more than a little surprised to find that it contained no reference to the use of arthroscopy in this procedure. Among its uses arthroscopy allows the clinician to comment on the macroscopic appearance of the synovium, examine the joint surfaces, and to find a suitably representative area of synovium for biopsy. The latter can reduce the "sampling errors" of a blind technique.

I am grateful that the leading article threw light on the types of synovitis and their histological differences, but I am sure that many of us involved in synovial biopsy, whether by needle or under vision with arthroscopy, are concerned by the number of times the report simply states a non-specific inflammation.

Surely it is only by building up experience

of macroscopic and microscopic features that a better differential diagnosis of synovitis can be obtained.

MICHAEL EDGAR

Royal National Orthopaedic Hospital,
Stanmore, Middlesex

Epidemiology and public health in American universities

SIR,—May I draw attention to a slip somewhere between pen and print which changed "without" to "with" in my recent article in your columns? (23-30 December, p 1737)? Neither W T Sedgwick, professor of biology and public health at Massachusetts Institute of Technology, or C-E A Winslow, first professor of public health at Yale, had medical degrees. Indeed a purpose of this passage was to draw attention to the fact that some of the leading early teachers of epidemiology in the United States, though bacteriologists, were *not* medically qualified.

Sedgwick embarked on a medical course (at Yale in 1877) but was so disillusioned with the unscientific approach to the subject there at that time that he left New Haven for Johns Hopkins, where he studied biology.¹ Winslow, who was a pupil of Sedgwick's, never studied medicine at all, and as a bacteriologist directed courses in his new department at Yale towards scientists who did not have medical degrees.²

ROY M ACHESON

Department of Community Medicine,
Addenbrooke's Hospital,
University of Cambridge

¹ Curran, J A, *Founders of the Harvard School of Public Health*. New York, Josiah Macy Jr Foundation, 1970.

² Acheson, R M, *American Journal of Epidemiology*, 1970, 91, 1.

Abortion and the NHS

SIR,—An analysis of the first decade of legal abortion in England and Wales is timely because the Wessex Regional Health Authority is now considering whether or not to introduce a regional day case abortion unit. Dr F G R Fowkes and others (27 January, p 217) present a case for more NHS abortions, but do not say whether such provision should be at a district or regional level.

The chief argument against the status quo is the "unfairness" of abortion provision, district by district and region by region. However, there is evidence that these disparities are lessening, not only from the paper by Fowkes *et al* but also from the Wessex abortion study.¹ A second argument is the different provision between the private sector and the NHS. In particular, single women aged 17-34 are less likely to get NHS abortions and more likely to be aborted in a private clinic. In practice, the private sector offers abortion almost "on demand," whereas the doctor in NHS practice is more likely to be selective. There are two reasons for this: NHS doctors on average tend to interpret the 1967 abortion act less liberally and, secondly, they are constrained by a shortage of resources for all forms of gynaecological care. The Wessex study has identified this fact and shown that districts where resources are less than average tend to do less abortions.

Like mixed sex wards, day care units are now the administrator's dream. Superficially it

seems that here is a way to save money and reduce waiting lists; but in practice day care units are very demanding and complex to run, and many of the savings are spurious.

There are no medical arguments in favour of increasing the number of NHS abortions vis-à-vis private abortions: the arguments are emotional and political. At a time when other types of private medical care are substantially increasing and when NHS waiting lists of all kinds are getting longer, it is difficult to understand why abortion should be singled out for priority care. If more money is spent on abortion units there must be less money for other patients.

Already NHS abortion practice is becoming more even-handed throughout the land. To develop regional units would polarise attitudes and distort the equitable and proper district developments for gynaecological services. It would be better to increase the allocation of money at each district gynaecological unit and encourage current trends.

ANTHONY NOBLE

Royal Hampshire County Hospital,
Winchester

¹ Ashton, J R, *et al*, *Second Report of the Working Group set up by the Wessex Regional Health Authority with the University of Southampton to Study the Provision of Induced Abortion and Abortion Related Services in Wessex*. University of Southampton, July 1978.

SIR,—The recent review of the first decade of experience of the Abortion Act (1967) (27 January, p 217) confirms what we have said in various places since 1971.^{1 2} The decline in mortality and morbidity rates, the use of concurrent sterilisation, and the shorter duration of pregnancy at abortion, particularly within the NHS, are also welcomed by us. However, it is not enough that we should merely accept this situation.

Comparison of the results of abortion obtained by the NHS and by the charitable and private sector shows so clearly how the results and the services could be improved immediately and considerably with almost no additional cost to the NHS. We can only conclude that the major factor responsible for the provision of poor abortion services within the NHS is reluctance on the part of the gynaecologists and health administrators who should be concerned. General practitioners are much more aware of the needs than the specialists, and the public has been unflagging in exerting pressure for the provision of humanly sensitive, safe, early, and efficient abortion.

An ill-informed spokesman for the DHSS made a hasty reply³ to our letter (19 August 1978, p 562) drawing attention to the differential mortality rates for abortion between the NHS and the private sector. We were promised early publication of the facts to rebut our suggestions that the NHS is still carrying out abortions too late, using inappropriate techniques, too often combined with sterilisation, and too often by relatively inexperienced operators. Later the DHSS suggested to us that our observations were a matter for the profession rather than the Department. We fail to understand how the profession can draw conclusions without the facts, which remain unpublished and which the DHSS surely have. As the delay in obtaining this information increases, we feel bound to ask the DHSS once again to provide the public and the profession with information that would enable the quality of our abortion services to be improved. We have personally asked the

DHSS to provide us with information that would enable us to decide whether or not our criticisms are still justified. We wait for a reply, but until then we do not intend to let the matter rest.

COLIN BREWER

Department of Psychiatry,
University of Birmingham

PETER J HUNTINGFORD

Department of Obstetrics and Gynaecology,
London Hospital Medical College,
London E1

¹ Huntingford, P J, *Lancet*, 1971, **1**, 1012.
² Brewer, C L, *New Society*, 1977, **39**, 281.
³ *The Times*, 22 August 1978.

SIR,—The paper by Dr F G R Fowkes and others (27 January, p 217) raises again the question of the great variation in the availability of abortion between the various regions of the NHS. These variations are even more striking when the analysis is carried down to district level¹; thus in 1977 five districts provided NHS abortions for less than 10% of women obtaining abortions, while seventeen provided for more than 90%.

As the authors indicate, the main reason for the inadequate performance of the NHS with regard to abortion is the unwillingness of the Service to make due provision. This is confirmed by the researches of Maresh² of Doctors for a Woman's Choice on Abortion, which have shown little correlation between abortion provision and the general availability of gynaecological facilities. In many cases the chief difficulty has been the opposition to abortion shown by senior gynaecologists; it is no coincidence that the decision of the West Midlands RHA to improve its own services came in the year before the region's chief gynaecologist was replaced by a man of very different opinions.

It may well be that health authorities have failed to provide proper abortion services for fear of pressure from the anti-abortionists, as the authors suggest. Such fears, if they exist, are not only undemocratic (for large majorities of doctors and of the general public support a liberal abortion law) but also ill founded—last year, despite a major campaign by the anti-abortionists, the letters received by the West Midlands RHA were about equally divided between those for the day-care clinics and those opposed to them.

DAVID FLINT

Abortion Law Reform Association,
London N1

¹ Abortion Law Reform Association, *Meeting Women's Needs*, 1975-6, and 1977 suppl. London, ALRA.
² Maresh, M, *Regional Variation in the Provisions of NHS Gynaecological and Abortion Services* (unpublished).

SIR,—Snide references such as the last paragraph of the letter from Dr Mary K Belton (10 February, p 415), made without supporting data, seem more appropriate to the correspondence columns of the popular press than a scientific journal. She suggests that the low rate of sterilisation in the private sector is due to there being "no incentive to kill the goose that lays the golden eggs."

The private sector exists to meet a demand and not to create one. The charities operate in a similar manner. The British Pregnancy Advisory Service started female sterilisation in 1971 when 15 sterilisations were performed, 13 of which were combined with termination of pregnancy. In 1977 the number was 1003, of which 588 were combined with termination

of pregnancy.¹ Over the same period the number of terminations of pregnancy increased by 28% but there was a 66-fold increase in the number of sterilisations.

Two more figures may help to nail the innuendo of Dr Belton. In 1971 there were 24 vasectomies performed by BPAS. In 1977 the number was 4601.

REX BINNING

Hove, Sussex

¹ British Pregnancy Advisory Service, *Abortion Today*. London, BPAS, 1978.

Industrial anarchy in the NHS

SIR,—Your leading article "Industrial anarchy in the NHS" (10 February, p 364) is a disaster. What are you trying to say?

"The prime cause of the industrial anarchy . . . is that strikers risk little by their actions." Should they risk more—presumably their jobs? "Union platitudes about patients not suffering have become seen to be false (and doctors who themselves argue a case for limited industrial action should remember that)." Does this add up to an instruction that resignation is the only weapon left to the BMA? I am rapidly coming round to that idea myself, but then you go on, "The NHS is overmanned (at virtually every level)." Too many doctors as well? But read on. "Lower-paid workers can be given a reasonable rate of pay if the total NHS work force is reduced by a realistic examination of staffing establishments. If the unions are really concerned with the interests of their workers they will co-operate in such a plan." For "lower-paid workers" read consultants. Ah, I have it—you want me to resign and risk my job so that my pay can be divided up among my colleagues who keep a "low profile" and stay in post.

"What has become plain in recent years is that militant industrial action has usually brought immediate rewards" and your leader follows with a quote from Dr Roger Dyson: "So long as the NHS continues to settle its strikes in ways that are immediately favourable to the striking staff it will encourage more strikes. . . ." Presumably you disapprove of strikes; but I quote minute 12 of the Hospital Medical Staff conference of 1977 under Incomes Policy: "[This meeting] is opposed to the extension of the pay policy proposed by government; it therefore instructs the CCHMS to prepare for the introduction of appropriate industrial action, preferably in collaboration with other crafts and commencing with a one-day national withdrawal of services." Our cry of "Enough is enough" then may apply to other groups today. "The number and frequency of stoppages, works to rule, and all-out strikes within the hospital service have, however, now become unacceptable to doctors, nurses, patients, and the public." Since your leader seems to refer to other workers do I take it that there is still approval for the juniors' action that won them their contract? But a consultants' work to rule is condemned—why? Because it was moderate or because it achieved little? The juniors have now broken away from the Review Body and the consultants are watching the outcome with great interest; this year's Review Body report must settle the issue.

So what have consultants got to look forward to? An 8.8% wage increase this year? Perhaps because we are already "so well off" we will be asked to forgo some of this, seeing the mess the country is in and bearing in mind that we may get our phased award. In this climate do we really expect "more cash on the table" for a realistic pricing of our work under the new contract? Mr David Bolt indicates that the contract negotiations will have been a waste of time if no extra cash is forthcoming. What does the CCHMS executive do then—resign? What action can it call for? If further suffering for the patient is unacceptable now, it will absolutely stink by the summer. Will the consultants resign—which is perhaps the most ethical course? They made much noise over Goodman, but few tendered

their paper and I still hear of some who said "What if they accept my resignation?"

"Can anything be done to prevent recurrences of the present epidemic of industrial unrest in the NHS? We think the condition is treatable." Who are "we"? Is your leader the authorised voice of the BMA? The *Daily Telegraph* certainly thought so on 10 February. Or are "we" a group of writers or even the Editor? Instructions for authors extol the virtues of brevity and plain English, and "We think the condition is treatable" boils down to "Yes" in the above context. But things are more subtle than that, for the whole idea behind your leader is that the disease is union militancy (BMA excluded?) and that the BMA is going to act as physician to the sick. The only snag is that the patient does not care for our diagnosis or treatment, and who can blame him? For if the reader turns to page 369 of the same issue he will find a paper by Professor R E Kendall, who refers to those "most innocent and dangerous of all medical assumptions: that when patients improve it is because of the treatment they have received. . . ."

If the BMA has any sense it should stay out of it and not exhort "any doctor who believes that an industrial dispute was a factor in the death of one of his patients" to "speak out." This type of comment *must* be left to those properly charged with the maintenance of standards, namely the Joint Consultants Committee and the Colleges. The concept is anyway suspect for industrial disputes in British Leyland reduce available funds for the rest of the nation and thereby directly contribute to poor patient care and death (from renal failure, for example). For doctors to turn on fellow Health Service workers who just happen to be nearer the end of the chain of events than the car workers, and especially on those who "are amongst the lowest paid in the country" is bad enough; but you add, "the DHSS should tell its managers that the 'low-profile' that it seems to have encouraged should cease." This haughty attitude by the medical profession can only extend the class-war battleground in the hospital service and promises a bleak future for the innocent patient, as those in some private beds have already discovered.

Finally, I refer to motion 207 by Bromley at the Annual Representatives' Meeting of last year under the heading "Industrial action by ancillary staff," which read: "That this meeting deplores the disruption in the clinical care of patients caused by industrial action on the part of groups ancillary to medicine who work in the National Health Service." The atmosphere of the meeting was that of your leader and I rose to speak after about 10 others had vented their spleen on the "unions." I put the case I have tried to explain here and proposed that the meeting "move to the next business" (which means that discussion ceases without a vote). It was carried, I think unanimously. I wish your leader had followed BMA policy and done likewise.

RICHARD MARCUS

Stratford-on-Avon,
Warwick

SIR,—Your leading article "Industrial anarchy in the NHS" (10 February, p 364) asks doctors to speak out if a patient dies because of a dispute. Why wait for death? Delays are already denying our patients relief from suffering: the public health has been put at risk.

Moral standards have declined and our professional integrity is in danger of erosion, but we must never betray our patients' trust. Some other way must be found to solve the problems of the underpaid.

We know that strikes involving the Health Service are evil. And it follows that, no matter how great the pressure of circumstances,