necessary concomitant supportive therapy must continue. However, the necessity and desirability of treating all patients with AML with aggressive chemotherapy has been questioned.⁴ We were impressed with the ease with which early control of the disease was achieved without upset to the patients. Expensive supportive therapy was not necessary and this treatment allowed early discharge from hospital. If our findings are confirmed by further experience we would suggest that this type of regimen might have a place in the initial treatment with the aim of producing good partial remission and a return of the patient to reasonable health. From consideration of psychological, physical, and family factors patients could then be assessed for suitability for more aggressive intensive cytotoxic therapy. Whether the initial therapy would influence the incidence of complete remissions or the duration of survival remains to be answered. We feel that further study of the use of razoxane/cytarabine in AML is justified.

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¹ Hellman, K, et al, *Current Chemotherapy. Proceedings of the 10th International Congress of Chemotherapy*, Zurich, Washington, DC, American Society for Microbiology, 1978.

² Gale, R P, and Cline, M J, *Lancet*, 1977, **1**, 497.

³ Rees, J K H, et al, *British Journal of Cancer*, 1977, **36**, 770.

⁴ Burge, P S, et al, *Lancet*, 1975, **2**, 621.

Maternal nutrition and infant birth weight

SIR,—Perhaps I could reply to the criticisms of Mr M D G Gillmer (29 July, p 353) on our paper "Maternal and fetal nutrition in south India" (10 June, p 1517). Our study involved one visit to each mother shortly after birth. A more elaborate study including observation throughout pregnancy has been undertaken in Vellore by Professor P S S Rao and his colleagues. This involved simple anthropometric measurements collected by non-medical staff. We felt that it would be valuable to study infant anthropometric measurements collected by one medical observer in an internationally acceptable way. We also studied maternal skinfold thickness. This measurement does not have the interpretational problems secondary to oedema of maternal weight measurements and maternal weight gain. It is also simple to perform and is acceptable to ordinary Indian women. There is no evidence that the nutritional patterns of these women change during pregnancy and therefore triceps skinfold thickness reflects nutrition as well as any simple measurement could do.

There were indeed maternal height differences between our paying and non-paying groups. Our results on the whole series, however, show correlation between maternal skinfold thickness and all infant measurements, whereas maternal height was correlated only with infant weight and length. It is therefore unlikely that the social class difference in infant size can be explained by maternal height variation alone.

Our study was limited by the length of time of my fellowship in India. It was also limited by the very different obstetric and paediatric climate in Britain compared with that of

India, where the majority of infants are delivered outside hospitals. Nevertheless, we studied a population in which maternal malnutrition is common and in which there was maternal smoking. This would be impossible in Britain. We believe that the conclusion we reached that the nutrition of the mother affects the nutrition of the baby is valid.

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Intrathecal penicillin

SIR,—We are perturbed whenever we hear of a death as a result of intrathecal injection of excessive amounts of benzylpenicillin. It appears that some clinicians are unaware of the neurotoxic effects of penicillin despite coverage of the subject in textbooks and in our data sheet.

After intravenous or intramuscular administration and in the absence of meningeal inflammation little penicillin enters the cerebrospinal fluid owing to the blood-brain barrier. However, even in this situation very large doses systemically (as are sometimes used in the treatment of bacterial endocarditis) or in severe renal failure doses above 6 megaunits daily¹ can produce encephalopathy with convulsions.

Intrathecal injection bypasses the safeguard afforded by the blood-brain barrier and it is imperative that only a small dose be given. The usual dose for adults is 6 mg (10 000 units) dissolved in 10 ml of sodium chloride injection BP and injected slowly once daily. For infants and children 0.1 mg (170 units) per kg body weight, diluted appropriately, is recommended.

F C WOOD
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¹ Beeley, L, *Prescribers' Journal*, 1977, **17**, 1.

Misuse of hypnosis

SIR,—Dr H B Gibson should not take exception to my words (30 September, p 957). The policy of the British Society of Medical and Dental Hypnosis is to teach hypnosis to doctors and dentists and to psychologists with a higher degree in psychology and working in the field of research or in hospital practice within a psychiatric unit.

Additionally, I need hardly remind Dr Gibson that I was one of the original supporters of his idea of a British Society of Experimental and Clinical Hypnosis for membership by those who fall within the latter category. The term "lay" refers to those who set themselves up as therapists without such qualifications and to stage performers.

I would refer to point (5) in my letter (19 August, p 571), which states: "The use of hypnosis is a psychotherapy and as such should only be used by those properly trained. . ."

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Health Service Commissioner and the Rhyl case

SIR,—Now that the Select Committee on the Parliamentary Commissioner, in its Fifth Report, has expressed confidence in the Health Service Commissioner's handling of the "inhuman" Rhyl case hospital doctors have some idea of what can happen when complaints are made against them.

A senior house officer at Rhyl sent a patient 103-years-old back to a local authority home at 2 am on 29 November 1976 after determining that she had sustained no fractures in a fall at that home. The ambulance was diverted to deal with an urgent case and her departure delayed for 50 minutes. She died on, or shortly after, arrival at the residential home. The written complaint about her discharge arrived on 13 December, but "owing to a misunderstanding" the views of the doctor on the complaint were not obtained. The doctor left the country early in 1977 before the senior consultant surgeon had had "an opportunity to discuss with him the complaint about the handling of the case." The Health Service Commissioner investigated the case without interviewing or contacting the doctor. The health authority did not contact the doctor when the commissioner's draft was submitted to it for comment. The commissioner's description of the decision to discharge the patient at 2 am as "inhuman" was then published.

The NHS Act requires the commissioner to "afford to any other person who is alleged in the complaint to have taken or authorised the action complained of, an opportunity to comment on any allegation contained in the complaint." Because the doctor was not "named in the complaint" the commissioner said he was not under a legal duty to give that opportunity.

Following publication of the commissioner's report the health authority embarked on another investigation and, over one year after the events, at last, on 5 January 1978, sent the doctor the letter of complaint, the hospital medical records, and part of the commissioner's report and asked four specific questions to which the doctor replied on 10 January 1978. The authority established that the patient had repeatedly asked to go back to the home but did not ask the doctor whether he knew that and took it into consideration.

If a court of law or a tribunal were to deny a defendant or respondent the opportunity to defend himself its decisions would certainly be quashed by a higher court. This is what the Select Committee might have been expected to do. Instead, they listened to evidence from eight "witnesses," none of whom had any first-hand knowledge of the events of 29 November 1976, and then confirmed the decision. Why? Their reasons seem to be:

(1) "Res ipsa loquitur"—the thing speaks for itself and admits no defence.

(2) Having made the clinical decision that the patient was fit to go, the doctor should have made an administrative decision to detain her till the morning because of her age.

(3) As to her own wish to go home, there was no evidence that the doctor took her wishes into consideration—whether he did or did not was not one of the four questions sent to him by the health authority—and in any case the wishes of a centenarian patient do not deserve great emphasis.

(4) The consultant (who had not discussed the complaint with the doctor) said he

regarded the decision as "indefensible" and that the patient should not have been discharged no matter how overcrowded the hospital might have been.

(5) The complaint is primarily against the authority and not against the individual doctor.

Of course the Select Committee said it would have been "appropriate" for the commissioner to have contacted the doctor and that the authority should have done so initially, and they "note" that the authority did not contact the doctor when the draft report was submitted for comment. But they confirmed the decision and they confirmed it without contacting the doctor themselves.

Meanwhile, in America, the senior house officer comes off best. He now lives in a country where all men can defend themselves if complaints are made against them. But we don't.

DAVID L WILLIAMS

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Distribution of registrars

SIR,—Professor L P Le Quesne (2 September, p 697) has suggested that calculations involving the redistribution of senior registrars should take account of work done by university staff holding honorary contracts with the NHS. However, not all clinical university staff hold honorary contracts with the NHS. The Sheffield Area Health Authority (Teaching) issues honorary senior registrar contracts to doctors employed by the Medical Research Council, to research fellows financed from outside sources, and to members of the armed forces on secondment, but not to lecturers employed by the University of Sheffield. As the Sheffield AHA (T) is part of the Trent Regional Health Authority, Mr V M Demmery (23 September, p 898) has continued to overestimate the "deficiency" of general surgical senior registrars in the Trent Region.

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Medical care in inner cities

SIR,—The volume of correspondence on the problems of medical care in inner cities is a measure of the concern of our profession.

What is needed is to attract highly motivated, vocationally trained doctors to accept the challenge of a changing and disadvantaged population. The special medical and social problems must be seen as worthwhile tasks. However, it must be accepted that the pattern of the classic family doctor who lives on the premises may have vanished in these areas. Incentives will be needed, both in the form of enhanced remuneration and by the provision of high-standard premises, equipment, and back-up staff. New attitudes will be required of hospital colleagues, not least those in the teaching hospitals, to accept the burden of back-up and encouragement to the troops in the field.

So far there have been few attempts to plan a realistic programme to meet the difficulties of these areas. It is therefore a pleasure to report that the North-east Thames Regional Health Authority, which is acknowledged to have the worst problems in the country, has recently produced a comprehensive discussion document¹ on practical measures which could be taken to reverse the crisis situation in its

inner city boroughs. This will cost money. Stated DHSS policy since 1976 has been directed towards (a) achieving an equitable distribution of health care resources throughout the country²; and (b) securing a shift of emphasis from secondary/institutional to primary/community care.^{3,4} The RAWP exercise has ensured that hospital resources are being shifted from these already disadvantaged areas. Under these circumstances inner London general practitioners are unwilling to erode further the hard-pressed hospital services. They do not want to rob Peter to pay Paul. The only alternative is to inject additional capital into primary health care in these special areas and this should become the declared policy of our Government.

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¹ North-east Thames Regional Health Authority: *Planning for Primary Care, A Discussion Document*. London, NE Thames RHA, 1978.

² Department of Health and Social Security, *Shaping Resources for Health in England, Report of the Resource Allocation Working Party*. London, HMSO, 1976.

³ Department of Health and Social Security, *Priorities in the Health and Personal Social Services*. London, HMSO, 1976.

⁴ Department of Health and Social Security, *The Way Forward*. London, HMSO, 1977.

Emergency allowances in the community health services

SIR,—I wish to draw attention to the anomaly now existing in the community health services.

It has been the custom to date in some districts, including this one, for senior medical officers (a number of whom have a higher qualification in public health) to take part in the duty rota for emergency calls for infectious diseases. More recently the newly appointed senior registrars in community medicine have joined the rota. Under the new pay awards for community doctors the latter, who are doctors in training, will now receive considerably more remuneration for this duty than the former, who are doctors in established grades.

Presumably all doctors on the rota are equal, but some are more equal than others.

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*.*The Secretary writes: "The Negotiating Subcommittee of the Central Committee for Community Medicine has always considered the emergency rota allowances to be derisory and is pressing for them to be increased."—Ed, *BMJ*.

Fair play for pensioners

SIR,—The recent Review Body recommendations, for all that they are not to be implemented in full (as usual), were not unrealistic. They do, however, especially in the way in which they are to be actioned, make bitter reading for doctors compelled to retire because of ill-health, as I was myself, before April 1978. Doctors working up to April 1979 will suffer a considerable loss compared with what they should have earned, but it is a once-for-all sacrifice and dynamising factors by that date will make pensions look a lot healthier. But the Review Body figures were intended to take account of what doctors should have been paid during the two years up to April 1978

and to make good the loss by a 28% increase at that point. Greatly to oversimplify figures, this implies that every £100 a doctor earned in December 1977 should have been about £120, and this "rise" should have been reflected in his pension.

I accept that it is never possible completely to correct all pay anomalies that arise, but I suggest that it is simple justice that doctors forced to retire before they could benefit by the new dynamising factors should at least receive pensions reflecting the implied intentions of the Review Body and the virtual admission of Government that the recommended increases were absolutely justified.

We haven't got much muscle as a group, but by heaven we have endured the "burden and heat of the day" since 1948 and we should surely be able to look to the General Medical Services Committee and the BMA to press for a fair deal.

DENIS CASHMAN

North Shields, Tyne and Wear

*.*The Secretary writes: Attention is drawn to the statement by Dr B L Alexander, chairman of the Superannuation Committee, to the Annual Representative Meeting (5 August, p 444). His committee has already made representations to the Department of Health and Social Security on this matter."—Ed, *BMJ*.

War service and NHS pensions

SIR,—It is now two years since the announcement (27 November 1976, p 1337) that HM Government was prepared to recognise war service as additional years of service for NHS pension purposes. It is nearly a year since the Department of Health and Social Security agreed to deal first with the oldest pensioners "as they are likely to be in the greatest need" (24-31 December 1977, p 1680). It would be interesting to know how many (if any) retired doctors have yet received any addition to their pensions in respect of their war service.

I retired 14 years ago and I am informed that I still have to wait for a further two years (should I live so long) before I shall receive any addition to my pension in respect of my four years of war service. This information was conveyed to me by the Department in a mimeographed letter, obviously prepared for wide circulation to retired doctors.

Several factors contribute to the delay. Principal among these is the fact that contributions by the doctor to the superannuation scheme were not paid during his war service and are being treated as a debt in arrears. Compound interest at 3½% from 1950 to 1975 is added, multiplying this "debt" by a factor of 2.37, and the additional "lump sum" payable to the pensioner is insufficient to pay this "debt." The balance of the "debt" is paid by withholding the increase in pension until the debt is satisfied. The increase dates only from July 1975 for doctors who retired before that date.

A debt paid in arrears with compound interest is a debt fully paid, and a debtor who pays his debt in full is surely entitled to the full benefits for which he pays in full—that is, the relevant pension from the date of his retirement. Doctors not yet retired will in fact receive the additional pension from the date of their retirement. If the Government did not intend that doctors already retired should