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Correspondents are urged to write briefly so that readers may be offered as wide a selection of letters as possible. So many are being received that the omission of some is inevitable. Letters should be signed personally by all their authors.

The pay-bed issue

SIR,—As I am probably the only surviving member of those who took part in the early negotiations concerning pay-beds within NHS hospitals I feel that certain facts should be put on record. I was a member of the Joint Consultants Committee from 1948 to 1972 and was its chairman for over eight years.

It is generally recognised that the profession's entry was facilitated, or even made possible, by Aneurin Bevan's undertaking to allow private pay-beds within some NHS hospitals. This was confirmed personally by him, and every subsequent Minister of Health was specifically asked if he endorsed this principle. In each case he agreed. There was no doubt that the profession was led to understand that the Government would act in good faith and honour the agreement.

Early on in the Service I had detailed discussions with Sir Wilson Jamieson and other officers of the Department regarding the siting of private beds and such issues as the charging of fees. Most of the beds were in private blocks or wings donated by benefactors to the hospitals concerned and initially it was felt that the question of fees could, as in the pre-Act days, be left to the good sense of the consultants. However, this matter, in departmental phraseology, was "taken away" for further discussions and emerged many months later with a whole host of complicated schedules which applied to the majority of pay-beds. The number of "open" fee (section 5A) beds was very restricted. These schedules occasioned a great deal of confusion and dissatisfaction and were only removed years later by the then Minister of Health, Kenneth Robinson, as part of a package deal.

I am convinced history will prove that the initial success of the NHS was basically due to the unstinted efforts of medical, nursing, and ancillary staffs. The Ministry of Health at the outset was nowhere near geared to handle the enterprise and there seemed to be little or no conception of the material or financial commitments that would be involved. While the central administration expanded from Whitehall to Savile Row and finally to the Elephant and Castle and regional boards were struggling with more local problems, doctors in their surgeries and hospitals were spending far more than their contractual hours and accepting many inconsistencies. Resources in manpower, material, and money never matched demand and probably never will, but over those years the profession assuredly fulfilled its side of the bargain and in its turn had and has every right to expect the principle of pay-beds to be honoured.

From the outset of the Health Service individuals, committees, working parties, and reports have stressed the danger of a learned profession becoming subject to a monopoly employer who might override the wishes of that profession or even callously dishonour its original undertakings. The danger now is not only the loss of pay-beds; it is the real possibility that Government can dictate the future of medicine. In spite of statements to the contrary the freedom of the profession is at risk.

When I retired (or, more correctly, was retired) from my NHS hospitals understanding between the profession and the Department was reasonably good and its acts constructive. Also morale was high. How is it that within a few years there should be such complete loss of confidence and such a catastrophic fall in morale? The tragedy is that at a time when the Service urgently needs support it is faced by political action that is bound to be disruptive and ultimately harmful to the community for whom the Health Service was created.

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Oestrogens as a cause of endometrial carcinoma

SIR,—Your leading article on this subject (3 April, p 791) drew an alarmist conclusion based upon so many suspect data that as one responsible for starting the first NHS menopause clinic in Britain I would welcome the opportunity to reply. Thankfully, it is true that the considerable positive benefits of hormone replacement therapy for those who need it are now beyond dispute, and our concern about possible side effects is reflected in the study of coagulation factors, endometrial biopsy specimens, carbohydrate metabolism, and mammography in our clinic patients.

The two American articles,[1 2] purporting to

show a 4·5- and 7·6-fold increase in carcinoma of the corpus in patients receiving oestrogen therapy are, at first sight, worrying. However, both series were retrospective analyses of case records with poorly matched controls of different socioeconomic groups, with no attempt to review the pathology before publication. Such a combination of sub-population bias and failure to obtain confirmation of the histology of an independent pathologist is lethal to any scientific conclusions whatsoever. The controls in the study by Smith *et al*[1] were women with carcinoma of the cervix (65%), ovary, and vulva, a population that is the very antithesis as regards parity and social status of women with endometrial carcinoma. The oestrogen-taking woman is one of low parity from a more privileged group of society who expects hormone replacement therapy, frequent follow-up, and a diagnostic curettage if breakthrough bleeding or post-menopausal bleeding occurs. The finding of a higher incidence of carcinoma of the endometrium in this group is a foregone conclusion but in no way implies a causal relationship.

The principal problem concerns the nature of the pathology in these studies. One suspects that in the American world of "defensive medicine" and private practice many would consist of hyperplasia or early tumours. Six months have now elapsed since the original articles appeared without the breakdown of the histological findings appearing in the medical press. It has, however, been obtained by telephone from one of the authors by a journalist and published in the *Guardian*,[3] *Toronto Globe and Mail*,[4] and *World Medicine*,[5] and in part in the data submitted to the special inquiry of the Food and Drug Administration (15 December 1975).

I feel compelled to reveal in this irregular form the data of other workers because I have no doubt that doctors and patients who may have been influenced by your leading article will be reassured to know that 95% of the "tumours" in the oestrogen group were stage 0-1 and that, as indicated in the accompanying table, the tumours in this group were the least advanced.

Stage	Oestrogen group	Non-oestrogen group
0 (hyperplasia) ..	16	7
1	129	115
2	6	20
3	2	15
4	0	7
Total	153	164
Invasive	17%	44%
Deeply invasive ..	1%	18%

It should be stressed that the use of two dissimilar groups for the study also precluded the conclusion that oestrogens protect against or produce a less aggressive form of tumour, but it can be safely stated that there is no clinical or epidemiological evidence that oestrogen in the doses used to treat the climacteric syndrome are in any way incriminated in the causation of endometrial carcinoma.

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[1] Smith, D C, *et al*, *New England Journal of Medicine*, 1975, **293**, 1164.
[2] Ziel, H K, and Finkle, W D, *New England Journal of Medicine*, 1975, **293**, 1167.
[3] *Guardian*, 25 March, 1976.
[4] *Toronto Globe and Mail*, 24 March, 1976.
[5] Cooper, W, *World Medicine*, 1976, **11**, No 12, p 27.

SIR,—I have read with great interest your leading article (3 April, p 791), because of my special interest, for over 35 years, in the problems of the menopause, and hormone replacement. There has been and still is a reluctance among physicians to treat women with oestrogens because of the widespread view that the therapy might produce cancer of the uterus or breasts. The hormone theory of cancer is full of contradictions and based on experiments on mice. However, some experts in this field have suggested that long-term administration of oestrogens does not increase the incidence of cancer, especially when combined with progesterone.[1-3]

My own observations[4] on 600 women, 300 of whom were treated with hormone implants and 300 who never received hormones, showed that among women of the same age group there were 7 cases of cancer of breast and uterus in the treated group compared with 17 cases in the non-treated group. Another study of 1000 menopausal women treated with hormone implants,[5] showed that among the first 150 treated with oestradiol only, the incidence of uterine bleeding was 20%, with two cases of endometrial cancer detected. In another group of 470 women treated with oestradiol and testosterone the incidence of bleeding was 8%, with two cases of cancer. In the group of 236 women treated with oestradiol, progesterone, and testosterone the incidence of bleeding was about 7%, with no cancer. The remaining women underwent hysterectomy before treatment with hormones.

The recent reports that you refer to[6 7] have caused much distress and alarm among women and hardened the attitude of physicians against the use of oestrogens. These authors concluded retrospectively that a large number of women with endometrial cancer had previously been treated with oestrogen, especially in the form of conjugated oestrogen (Premarin). In this respect reports by Siiter *et al*[8] are worth mentioning; they point out that among the three fractions of oestrogen, oestriol, oestradiol, and oestrone, a special intimate relationship exists between oestrone and the receptors in target tissues of the endometrium. Their "oestrone" theory suggests that unopposed exposure to oestrone may be a factor in the development of cancer, while oestriol and oestradiol, especially in combination with progesterone, might have a protective effect. Another point of importance is the finding that androstenedione, which is produced in the adrenals and in the menopausal ovaries, is converted in the fatty tissues of the body into oestrone, which might contribute to the higher incidence of cancer in postmenopausal women.[9]

Practical conclusions would be: (1) To give an oestrogen preparation with a low oestrone content, preferably combined with a progesterone. The so-called natural conjugated oestrogens are supposed to contain a larger fraction of oestrone. (2) To give the hormone in the form of an implant, bypassing the gastro-intestinal tract and liver. The addition of progesterone might counteract the effect of oestrone. I would suggest that the fear of provoking cancer by prolonged hormone therapy is exaggerated and that the association between hormone therapy and cancer of the endometrium is usually coincidental. This minute risk must be balanced against the valuable effect of hormone therapy, preferably given by the implant method, which has been shown to give enormous relief to countless women in the climacteric and thereafter.

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[1] Burch, J C, *et al*, *Annals of Surgery*, 1971, **174**, 414.
[2] Wilson, R A, *Journal of the American Medical Association*, 1962, **182**, 327.
[3] Bakke, J L, *Western Journal of Surgery, Obstetrics and Gynecology*, 1963, **71**, 241.
[4] Schleyer-Saunders, E, *Proceedings of the 7th International Congress of Gerontology*, Vienna, 1966.
[5] Schleyer-Saunders, E, *Journal of the American Geriatrics Society*, 1971, **19**, 114.
[6] Smith, D C, *et al*, *New England Journal of Medicine*, 1975, **293**, 1167.
[7] Ziel, H K, and Finkle, W D, *New England Journal of Medicine*, 1975, **293**, 1167.
[8] Siteri, P K, *et al*, *Gynaecological Oncology*, 1974, **2**, 228.
[9] Schindler, A E, *et al*, *Journal of Clinical Endocrinology and Metabolism*, 1972, **35**, 627.

Liquor licensing and public health

SIR,—The latest lengthy contribution, by Dr B N C Prichard (17 April, p 956), to the debate on liquor licensing and public health has prompted us to write in response, as it exemplifies the one-sided nature of the debate.

Those who favour relaxation are accused of "proposing a gamble with the nation's health," and preservation of the status quo or further restrictions are advocated. There has been no consideration, except from Dr C W Clayson (13 March, p 649), that the existing regulations may be contributing to the problem. Government statistics from the Family Expenditure Study show that per caput consumption of alcohol in Scotland since 1961 is similar to that in the rest of the United Kingdom. Yet Scotland has a greater incidence of alcoholism and other kinds of drink-related harm in the presence of greater restrictions than the rest of the United Kingdom.

The evidence produced by Dr Prichard has to be questioned. He argues that "there is much information showing that consumption of alcohol is correlated with the incidence of alcoholism" without acknowledging that this has been severely criticised.[1 2] If the facts were as straightforward as is being suggested why does America, whose consumption is half that of Italy, suffer eight times as much harm? While it is true that the cirrhosis death rate fell during prohibition in the United States, there is some evidence that suggests that alcohol consumption actually increased.[3] Dr Prichard advocates "a long, hard look at France." Had he taken his own advice he might have reported that within France it is those regions with the lowest consumption that have the highest death rate from alcoholism and vice versa.[4]

Your plea (leading article, 14 February, p 359) for a united stand by the medical profession despite there being no clear evidence therefore seems rather premature and based on value judgement rather than scientific evidence.

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[1] Miller, G A, and Agnew, M, *Quarterly Journal of Studies on Alcohol*, 1974, **35**, 877.
[2] McKechnie, R J, Paper presented at 3rd International Conference on Alcoholism and Drug Addiction.
[3] Coffey, T M, *The Long Thirst: Prohibition in America, 1920-1933*. New York, Hamton, 1976.
[4] Sadoun, R, Lolli, G, and Silverman, M, *Drinking in French Culture*. New Brunswick, Rutgers University, 1965.