man was afraid of.

The J.H.D.A. would be wise to heed Mr. Elkington's warning in his excellent letter (6 June, p. 606). It is well to be long-sighted, and to remember they will some day occupy their elders' shoes. Perhaps, when this day comes, not only will they have some respect from the Government, but also a unanimous following from the junior members.—I am, etc.,

JAMES HARDWICK.

London N.W.3.

SIR,—During this present controversy over doctors' pay I have wondered whether anyone will take up the cause of the older general practitioners, who are in fact the real victims (apart from the hospital junior doctors) of the N.H.S. take-over in 1948. Our practices were compulsorily bought over and the money invested for us at 2½% until retirement.

Our ancillary help, the upkeep of our consulting rooms, rent, and rates had all to be paid for, not out of our salaries, but out of our savings, because of the capitation fee of 10s. per year. This fee rose after several years and disputes to 17s. 6d. at my retirement in 1960. I retired with the miserable pension of £250 per year.

Is there any hope the British Medical Association will take up our cause. I have been a member since 1924. There must be a good many colleagues situated as I am.—I am, etc.,

J. K. HUNTER.

Fordingbridge,
Hants.

SIR,—I am disgusted at the B.M.A. recommendations to doctors over the current pay dispute, and am seriously considering resigning my B.M.A. membership.

A differential pay rise benefiting hospital junior doctors (I am a general practitioner) was much needed and I believe the Review Body to be mistaken in recommending such a large rise right across the board. The economy of this country is in a precarious state, to say the least, and general practitioners and consultants, who, I believe, are already well remunerated, should be prepared to set an example by lowering the bidding in the present wage inflation spiral. Instead we again are represented as a profession of money grabbers.

While no great friend of the present Labour Government, I am right behind them in their rejection of part of the Kindersley Report for reasons of overriding economic importance.—I am, etc.,

D. R. FRAMPTON.

Brentwood,
Essex.

SIR,—

"Look round the habitable world! how few know their own good; or knowing it, pursue"
Dryden, trans. of Juvenal.

The B.M.A. Council, moved by prevalent mood and philosophy, has spoken. If we gain our utmost hopes in money and lose respect and love shall we be happier? Many years ago I took part in a T.V. programme called "The Classes." After the showing a questionnaire was sent out and people were asked to say whom they thought came in the upper class. The popular vote put the doctors in the upper class.

Evidently our image and relations with the people were good. Now we are full of double-talk. Every workman can see it. We will not harm a single patient; we will see only "emergencies." We will treat our patients but not give them a certificate, for that will not incommode them. We will break our contract of service, for that is, we say, what the Government is doing. We will force the Government. We will take advantage of an Election.

When the crisis is past, and we have lost love and respect and somewhat split our profession, not all of whom favour the arbitrament of force even when law may be on our side (for there is more to lose than a legal battle), the better part of our colleagues may come to think in the terms used by a Prime Minister of France who said, after the Nazi intrusion into Austria (with whom France had a treaty of help but did not go to help), "I have a feeling of shameful relief." When we have got the money and that relief we may have time to remember, "Who steals my purse steals trash, but he who filches my good name steals that . . . which leaves me poor indeed." If you should publish this letter and someone should light on it in ten years'

District Health Authorities

SIR,—The medical staff of the Hereford Hospitals have discussed the second Green Paper¹ and have asked us to make their views known, believing that the social and geographical structure of Herefordshire creates problems not shared or appreciated by many other districts in the country.

Herefordshire, a moderately large county with a comparatively small population, is a natural unit for administrative purposes. It is served by hospitals and health services from Hereford conveniently situated in the centre of the county. The hospitals also serve part of Brecon and Monmouthshire and much of Radnorshire, areas which link more naturally with Hereford than with distant Welsh centres.

Close liaison between the three branches of the Health Service already exists here. We accept the need for unification but believe that the interests of all three branches would be sure to suffer if the proposed amalgamation with South Worcestershire, a smaller area with a larger population, were to take place. Our natural geographical unity would be destroyed and we would probably find ourselves struggling for a fair share of the national budget through an inadequate number of representatives at a remote area health board headquarters in Worcestershire. It is difficult to see how administrative officers at a remote headquarters could appreciate all the problems throughout a large rural area such as ours.

We believe that districts such as ours should have a health authority based on their district hospitals. The district authority should have a budget of its own and a regional health authority between it and the Department of Health and Social Security. Through the regional authority we would maintain links with our neighbours and with our regional university, which at present helps with postgraduate education over a wide area.

In addition we think that the second

time—when perhaps the attitude of the public to doctors has convincingly changed—might some say "In 1970 we took a wrong turn"?

My mind turns back to a bedside class of yester year—a crowded class. The eminent consultant was asking each student to hear a whispering pectoriloquy. "But Sir Robert," came a quiet voice from a professor's daughter, "I couldn't hear it." "Don't raise your piping voice against the orchestra" was the riposte. The orchestra may seem in tune with reality today, but what of tomorrow?—I am, etc.,

J. A. GILLISON.

London S.E.10.

SIR,—I am no longer working in the Health Service, and therefore questions of increases in pay no longer affect me directly. I would, however, like it to go on record that, in view of the state of the national economy and of the example set to other sections of the community, at any rate one member of the profession feels that the attitude of the British Medical Association in this matter is wrong.—I am, etc.,

London W.1.

DAVID PATEY.

Green Paper recommends inadequate medical representation on area health authorities. There should be a stated proportion of medical members instead of the proposed one-third from the health professions. We consider that the proposals would result in the Hospital Service being unable to obtain a fair share of money compared to the other branches.

We believe that the cost involved in changing the present administration would be better used in remedying deficiencies in the present inadequate service.—We are, etc.,

J. H. ROSS,

Chairman.

W. H. J. BAKER,
Secretary.

County Hospital
Hereford.

Group Medical Committee,
Herefordshire Group of Hospitals

REFERENCE

¹ Department of Health and Social Security. *The Future Structure of the National Health Service*. London, H.M.S.O., 1970.

Unexpected Death after Using Yates Drain

SIR,—I recently had a patient who, after a second block dissection of the right side of the neck, died unexpectedly. Yates drainage tubing had been used to drain the wound as suction drainage was not available at the time, and corrugated rubber drainage used on the other side of the neck had not drained the wound effectively.

On the evening of the operation the patient became blue and showed congestion of the veins in the arms. The following morning he was extremely well, and spent the afternoon and evening in the day room watching television. As there was still rather a lot of serous oozing from the wound the drains were not removed as usual after 24 hours, but were left for removal the next morning. Two hours after retiring the patient staggered from his bed to the ward

sister's desk in a state of asphyxia. Unfortunately, despite all attempts at resuscitation, he had a cardiac arrest within ten minutes and failed to recover.

Necropsy showed marked mediastinal emphysema, with some subcutaneous emphysema at the site of the operation. There was no possible source of this emphysema except from the wound. It seems most likely that the Yates drain allowed air to be aspirated into the wound on inspiration, particularly when the patient was lying in bed, and that expiration blocked the ends of the corrugated tubes, causing a ball-valve effect.

This seems a potential risk of Yates drainage tubing which I think needs to be appreciated by all surgeons.—I am, etc.,

DEREK G. JENKINS.

Medway Hospital,
Gillingham, Kent.

Use of Broad-spectrum Antibiotics

SIR,—Dr. M. Patricia Jevons takes exception to the summarized indications for Ampiclox Neonatal (ampicillin and cloxacillin) set out in the wall chart entitled *The Beecham Range of Penicillins* (May 30, p. 540). She disagrees specifically with the indication "Failure to thrive." I would agree that this term may be somewhat outmoded and embraces a number of possible diagnoses. When the use of this phrase was first drawn to our attention a few weeks ago we reviewed the situation and decided to omit it from future literature.

I would have thought, however, that the chart made it quite clear that Ampiclox Neonatal is only indicated for the treatment of those premature infants and neonates who fail to thrive because of "confirmed or suspected infection."

I do not consider that its administration in what may be a life-threatening situation constitutes "indiscriminate use of these valuable drugs." The use of any antibiotic will of course, tend to select strains of organisms resistant to it, but this fact must be weighed against the more immediate risk of withholding therapy in any given clinical situation.—I am, etc.,

E. T. KNUDSEN,

Medical Director,
Beecham Pharmaceutical Division,
Brentford, Middx.

SIR,—Dr. M. Patricia Jevons (30 May, p. 540) mentions some dangers of the use of antibiotics in neonates. May I add one more from personal experience?

When my daughter was born last year she was given a five-day course of intramuscular penicillin. I later learned that this was done routinely for all babies delivered in bed in the side ward rather than in the delivery room. We were not told of the treatment, and after two days my wife, who is mildly sensitive to penicillin, developed an irritating rash on her forearms. Fortunately the reaction was not severe and she was able to continue nursing the child, taking more care to avoid contact with the wet nappy.—I am, etc.,

J. R. COWHIG.

Department of Biochemistry,
University of Surrey,
Guildford, Surrey.

Screening for Lung Cancer High-risk Groups

SIR,—The results of the investigations of Dr. G. Z. Brett (1 November, 1969, p. 260) and Dr. F. A. Nash and others (22 June, 1968, p. 715) provide some encouragement for the belief that through earlier radiological detection a modest improvement in the prognosis of lung cancer can be achieved. The cost of identifying a potential survivor by serial radiography falls if persons with a greater hazard of developing lung cancer than average for the age-group in question are investigated.

For some years we have been studying the use of simple screening methods to identify such risk-groups in a prospective epidemiological study of 12,322 males residing in the Kolin district, Czechoslovakia, aged 40-64 years and having a normal chest x-ray on entry into the study. In the course of the first year of the study (1966) during mass survey of the population a photo-fluorogram size 70 x 70 mm. was done, and a brief interview held with each person. The questions asked by the medical auxiliary concerned smoking habits, cough during the past year, expectoration of sputum, blood spitting, and respiratory infections in the past year. Information on lung cancer cases diagnosed during the subsequent years was collected from notification cards, chest clinic and hospital records, and death certificates.

In this group 52% were cigarette-smokers, 12% ex-smokers, 2% cigar or pipe smokers, and the remaining 34% were non-smokers. Forty-one per cent. of the interviewed males had cough during the past year of at least three months' duration, and in 5% cough got progressively worse; 27% brought up sputum; 1.9% reported had had a haemoptysis in the past year, and another 1.8% had had a pneumonic episode.

Sixty-one proved lung cancer cases were diagnosed during the subsequent three and a half years—that is, an incidence of 1.41 per thousand yearly. The incidence was related to age. It was 0.37 per thousand in the group of 4582 males who were 40-49 years on entry into the study; 1.17 per thousand in 5117 men who were 50-59 years, and 3.70 per thousand yearly in 2623 men aged 60-64 years.

Cigarette-smoking was an important risk factor. In the group of 2707 smokers who had smoked 200,000 cigarettes and over there was a 4.64 per thousand annual incidence of proved lung cancer; in the group of 3627 smokers who had smoked less than 200,000 cigarettes, and in the group of 1487 cigarette ex-smokers, it was 0.87, and 0.96 per thousand, respectively. Only one of the 61 proved lung cancer cases was found in the group of 4271 non-smokers; it corresponds to the annual risk of less than 0.07 per thousand. Persons with a history of chronic cough (5002 men) were at a higher risk (2.74 per thousand yearly) than non-coughers (0.51 per thousand yearly).

An association between the following characteristics and the occurrence of lung cancer was also found: Men with a history of expectoration of sputum of at least three months' duration during the past year had a 3.30 per thousand annual risk of developing lung cancer; men reporting worsening of cough during the past year 4.39 per

thousand yearly; and men reporting haemoptysis during the year preceding the mass survey 10.20 per thousand yearly. Persons without these symptoms had an annual risk of developing proved lung cancer of 0.73, 1.27, and 1.25 per thousand, respectively. No significant predictive value of the history of a pneumonic episode during the past year was found in this study.

The brief standard interview done during mass x-ray survey is a useful screening method for identification of lung cancer high-risk groups among middle-aged males with a normal chest x-ray at that time.—I am, etc.,

ANTONÍN KUBÍK.

Tuberculosis and Respiratory Diseases
Research Institute,
Prague 8, Czechoslovakia.

Advanced Cancer of the Breast

SIR,—I congratulate Mr. John Hayward on a very lucid review of the controversial field of hormonal management in advanced breast cancer (23 May, p. 469). I was surprised therefore to read his opinion that the remission rate from bilateral adrenalectomy or hypophysectomy is "probably two to three times that of castration or hormone therapy." This has never been demonstrated in fact.

The literature is indeed fogged by different criteria of response, but the joint committee of the American Colleges of Physicians and Surgeons compared, in 1962,¹ the results of oophorectomy with those of adrenalectomy or hypophysectomy, using uniform criteria. When only premenopausal patients were compared, castration yielded tumour regression in 29.7% of 381 cases compared with 33.2% of 232 adrenalectomized cases and 31.1% of 74 hypophysectomized cases. The differences are not statistically significant.

Mr. Hayward may argue that the major ablative procedures tend to be used in the more advanced stages of the disease, and that the regression rate would be higher if they were used earlier, but he surely would not suggest that they could achieve regression in 60% to 90% of breast cancer patients (corresponding to "two to three times" the response to castration therapy). The "magic" figure of 30% crops up repeatedly as the regression rate from every form of endocrine therapy, including the better methods of additive hormone therapy. It is hard to avoid the conclusion that this figure represents the proportion with true hormone sensitivity in any large breast cancer series. One excludes, of course, those patients who after endocrine ablation or additive hormone therapy show dramatic but temporary relief of pain, without objective evidence of tumour regression.—I am, etc.,

BASIL A. STOLL.

Radiotherapy Department,
St. Thomas's Hospital,
London S.E.1.

REFERENCE

- 1 Taylor, S. G., *Surgery, Gynecology, and Obstetrics*, 1962, 115, 443.

Undergraduate Medical Education

SIR,—The Special Representative Meeting's tacit acceptance of the Todd report's¹ concept of undergraduate teaching was