Correspondence

Letters to the Editor should not exceed 500 words.

"Medical Assistant"

SIR,—I am in full sympathy with Dr. N. F. Crofts's letter (24 October, p. 1076); one can scarcely think of a more humiliating appellation. To remain or become an S.H.M.O. would be surely preferable, but why not "a chief assistant," an honourable title in the past, which would well fit the responsibilities of these new posts?—I am, etc.,

Cambridge.

T. J. FAIRBANK.

SIR,—Dr. N. F. Crofts (24 October, p. 1076) is right to draw attention to the undesirability of this title for qualified medical practitioners. I wonder whether those who selected the name "medical assistant" realized that it is already in use in many of the developing countries of the world. There it is used to designate local people who, normally after completing primary schooling, are given two or three years' on-the-spot training to enable them to help to run local medical services.

I know of a number of such medical assistants from Malawi who are now working as student nurses in Scottish and English hospitals in order to qualify as registered nurses.

To use a title for doctors here which is already in use for auxiliaries in other parts of the world would seem likely to cause unnecessary international misunderstandings in the future.—I am, etc.,

Bearsden, Glasgow.

DAVID STEVENSON.

SIR,—While I agree that the public image of the "medical assistant" would be a lowly

one, I must disagree with Dr. N. F. Crofts (24 October, p. 1076) when he describes the label as ambiguous and derogatory.

A soldier in the Royal Army Medical Corps who has no professional or technical qualification, but aspires to be something better than a general-duty orderly, used to be trained as a nursing orderly. About two years ago this trade was renamed medical assistant (PULHEEMS Administrative Pamphlet 1962, Amendments No. 3, Table II).

In my opinion there can be no ambiguity about the term "medical assistant." This surely describes someone who, himself without a professional qualification, assists a medical man or woman.

The label is far from derogatory. In the R.A.M.C. a Medical Assistant Class III has passed examinations equivalent to the first-aid and home-nursing examinations of the Red Cross Society or the St. John Ambulance Association. A Medical Assistant Class I approaches the standard of a State-enrolled Assistant Nurse. Even so, I should not appreciate being regraded as "medical assistant."

At present I give anaesthetics at my local hospital, and my appointment is described on some papers as "clinical assistant in anaesthetics," and on others as "practitioner appointed under the terms of Section 10(b)."

I have seen the terms staff-surgeon, staff physician, staff anaesthetist, etc., suggested for the new grade. Why not simply surgeon, physician, or anaesthetist?—I am, etc.,

Newark-on-Trent,
Notts.

W. H. VALENTINE.

Specialty of Chest Medicine

SIR,—Dr. Neville C. Oswald has presented in his article on the specialty of chest medicine (10 October, p. 935) the problems that confront administrators and clinicians in this field in a remarkably clear manner with sound and practical conclusions.

One sentence that is of great importance prompts me to make a suggestion that might help to relieve the "slow and painful" process of integration. Dr. Oswald states: "The proposed changes of emphasis . . . will be regretted by many chest physicians, particularly by those who carried the heavy burden of pulmonary tuberculosis and have been isolated from general medicine in recent years. Indeed, several arguments can be advanced for the continuance of the present organization." I doubt if anybody will disagree with this statement and there are many who believe that if tuberculosis is to be eradicated the tuberculosis service in all its aspects must continue. It should be remem-

bered that the old form of tuberculosis dispensary dealt with the diagnosis, control, and prevention of *all* forms of tuberculosis, and there was then less danger of an active case escaping notification than there is to-day when the chest physician and medical officer of health have only partial knowledge of the incidence of tuberculosis in the area they serve.

Tuberculosis in this country is declining, but the rate of fall in the incidence is too slow to hope for eradication for many years, and an extra drive against the disease is necessary if our efforts are to be successful within a reasonable period. Professor Etienne Bernard has said that the first country to achieve eradication of tuberculosis will be the one that sustains the effort continuously to the end. In Great Britain it would seem easily possible to do this, as the small band of physicians referred to by Dr. Oswald have the experience, knowledge, and ability to con-

centrate on the eradication of tuberculosis if they are given the opportunity.

It would be logical to employ these specialists in the work they can do better than anyone else by re-forming them into a service responsible directly to the Ministry for the detailed control and final eradication of tuberculosis in specific areas. This would be better than giving them posts they do not want and for which they are not suited.

Dr. Oswald quite rightly points out that there is little to induce able young registrars to embark upon a full-time career in chest medicine, and it is certain that none of them is going to specialize in tuberculosis. It therefore would be wise to use the available specialists, whilst they last, to the fullest extent to combat the disease which as Professor Crofton¹ has shown is still unconquered.

Not only would such action be beneficial to the national effort to eliminate tuberculosis, but it would also meet the sympathetic attitude that many lay councillors on health committees have towards the plight in which they see their trusted and well-known tuberculosis officer of other days placed after years of valuable service.—I am, etc.,

Caerphilly, Glam.

FREDERICK HEAF.

REFERENCE

- ¹ Crofton, J., *Brit. med. J.*, 1960, 2, 679.

Early Discharge of Maternity Patients

SIR,—It is with some hesitation that I write in criticism of Sir Andrew Claye's letter (17 October, p. 1007), for the content of his first paragraph is so reasonable. It is his second paragraph which in my view misleads.

His writing about obstetric care underlines the importance of what he calls "one authority" which he describes as the "general-practitioner obstetrician and midwife if she [the patient] is at home, and the obstetric team if she is in a maternity unit." Sir Andrew Claye may not have intended it, but he has without doubt conveyed the impression that the general practitioner is not a part of the team caring for the woman who is to be confined in a maternity unit. Surely this is wrong, even unrealistic, for however skilled the staff of the maternity unit are they are not likely to provide all antenatal care out of office hours. The patient with a pain coming on in the evening or on a day other than her particular clinic day will go, and should be encouraged to go, to her family doctor, who should already be sharing her care to whatever extent is appropriate in the particular case.

Clearly Sir Andrew Claye does not like the early discharge of maternity patients and he gives his reasons, but there are other considerations. For example, should a mother with a young child be separated from that child for longer than absolutely necessary, and especially when she can "lie in" perfectly well at home? I think not. And the patients chosen for early discharge mostly welcome it. Of 200 women recently dis-

charged between the second and the sixth day from the Jessop Hospital for Women 158 were satisfied, even enthusiastic, with the arrangements, 28 were doubtful (nearly always because of inadequate help in the home), and only 13 said they were not satisfied. One felt unable to give an opinion, having been readmitted with secondary post-partum haemorrhage. In practice, many patients specially ask to be booked for 48 hours, and there are a few who should be confined in hospital for medical reasons who are clearly very unwilling to come in unless short stay is promised.

Unlike Sir Andrew Claye I believe that for a proportion of patients the deliberate planning for a 48-hour discharge from maternity unit is the correct thing to do, for it provides the patient with the best of both worlds; this arrangement, however, must be planned in advance and must be supported by efficient lines of communication and a real sense of team-work among those providing maternity care. Above all, the patient's home conditions must be suitable for early discharge, and in particular there must be sufficient help to give the mother enough protection from the everyday affairs that she is going to have to take up again soon enough.—I am, etc.,

C. SCOTT RUSSELL.

Department of Obstetrics and
Gynaecology,
Jessop Hospital for Women,
Sheffield 3.

Measles Vaccine

SIR,—Dr. W. P. Sweetnam (17 October, p. 1011) mentions a case-fatality rate of over 1% in children under 1 year suffering from measles. This figure must surely be a hospital case-fatality rate. Dr. Miller's survey (11 July, p. 75), the most searching so far, shows a much lower figure—12 deaths in 53,008 notifications at all ages. Should all the deaths have occurred under 1 year of age the case mortality rate would still be well below 1%.

In Belfast during the last seven years (1957–63) there were four measles epidemics. From notifications and medical history of school entrants it is estimated that there were 48,000 cases of measles during the seven years. Hospital admissions amounted to 4%, compared with 1% in Miller's survey. The Registrar-General reports four deaths in Belfast due to measles in these seven years; one male infant under 6 months of age; one girl in the 1–4 years age-group, and three girls in the school age-group (5–14 years). The last epidemic, in the winter of 1962–3, with an estimated 12,000 cases, resulted in no deaths.

Hospital admissions emphasize the social aspects of this disease; almost 90% were from homes in the social classes 4 and 5.

To improve this situation a measles vaccine would require to give high, long-lasting immunity, noting that in Belfast the death rate is higher in schoolchildren than in the pre-school ages. Equally it would require to be universally acceptable in view of the social gradient. It would probably be acceptable only as a component of a combined vaccine.—I am, etc.,

W. J. MCLEOD,
Deputy Medical Officer
of Health.

Health Dept.,
Belfast 1.

Grease-gun Injury

SIR,—I would like to add two further cases of grease-gun injuries to Mr. Michael G. H. Smith's article (10 October, p. 918) that I have had in the last two months. One of these cases in particular demonstrates the need for wide exploration.

Case 1.—A 38-year-old garage proprietor was using a guarded Zerk nozzle, and while feeling blindly for the nipple injected a small quantity of grease into the pulp of his left index finger. We saw him two days later and he was treated with antibiotics for a further two days with very little result. The pulp space was then laid open completely—an area of about 1 sq. cm.—and a quantity of grease removed. A fortnight later this had healed satisfactorily.

Case 2.—Again a motor mechanic, who on 21 September 1964 was using an unguarded Zerk nozzle when he injected grease into his right index finger. His general practitioner sent him to us the same day. There was a small puncture wound in the lateral side of his index finger distal to the distal interphalangeal joint, and the distal portion of his finger was slightly swollen. Under local anaesthesia this pulp space was opened by a lateral and distal incision exposing grease extending across to the medial border of his finger. It was then obvious that the lateral incision had to be extended to the base of the finger and the flap turned medially, exposing the whole anterior surface of this flexor sheath and the area medial to this. All this area contained grease. After removal of the foreign material this flap was replaced and loosely sutured. The hand was immobilized for five days and antibiotics given. Sutures were removed on the seventh day. When the initial local infection and oedema had settled physiotherapy was commenced on the sixteenth day. By the twenty-first day an area of skin 1 cm. by $\frac{1}{2}$ cm. at the distal corner of the flap had become necrotic and separated. One month after the accident, with the wound healing satisfactorily, he has already recovered about 75% of active and full passive movements.

I would like to thank Mr. P. W. Seargeant for permission to describe these cases.

—I am, etc.,

Casualty Department, J. A. M. PHILIPSON.
West Norfolk and King's Lynn
General Hospital,
King's Lynn, Norfolk.

Attitudes to Nursing Among Intelligent Schoolgirls

SIR,—I would like to comment on the above article (17 October, p. 1001), as I consider this survey gives a very misleading picture of the efforts to recruit student nurses in the West Riding of Yorkshire. Although I am able to quote only accurate information about the hospital of which I am matron, I know that many of my colleagues would dispute the statement that relations between the schools and hospital boards are tenuous and that the hospitals make so little effort to reach the school-leavers by literature and invitations to visit hospitals.

Between September 1962, when the schools reopened, and January 1963 342 letters and 270 brochures of the School of Nursing were sent out from this hospital alone to headmistresses and headmasters. During the same period 947 girls from 43 different schools visited this hospital, and an additional 114 Girl Guides and youth-club members were given an opportunity of seeing the work in hospital. Between February 1963 and December 1963 a further 484 schoolchildren

from 19 schools and 30 other young people visited the hospital. The above-quoted figures are relevant to the period during which the survey was made, but I would add that such contact with the schools has been in operation for many years.

Since April 1962 careers conventions during the Easter holiday have been organized in conjunction with the Leeds grammar schools and the West Riding Education Authority. These conventions have proved so popular that they are now held for two whole days twice a year, during the Easter and Christmas school holidays.

As many of the candidates whom I interview inform me that they have visited their local hospital from school, I find it hard to accept the findings of a survey undertaken in six schools as being representative of the situation in the whole region. Granted many of the schoolgirls who have visited us are not really interested in nursing, and it is impossible to assess how many in fact have their interest stimulated during these visits.

One final point I would dispute is the statement that 260 girls interested in nursing is more than adequate to satisfy existing needs for the hospitals in the area defined. The number is in fact barely adequate for the needs of the three nurse-training schools in Leeds alone, and there are several other large hospitals in Bradford and Wakefield.^{1,2} One wonders upon what evidence the authors reached their conclusion, as I and my colleagues are not aware of having been consulted regarding our student needs or of providing information of the numbers of student nurses at present recruited from within this area, or the numbers of local schoolgirls who go to other parts of the country, particularly London, to train.—I am, etc.,

G. E. WATTS,

Matron,
The General Infirmary at Leeds.

Yorkshire.

Hepatic Amoebiasis

SIR,—Your leading article on hepatic amoebiasis (25 July, p. 206) deals with a very interesting subject. You are absolutely right in saying that it has always been difficult both to diagnose and to understand hepatic amoebiasis, also that problems in this field remain. Immediately afterwards, however, you specify the problems as being abscess of the liver and amoebic dysentery. Both these forms are acute episodes very common in tropical countries, and there are many doctors in those countries who are well acquainted with their clinical symptomatology and treatment.

The real problem lies in the chronic forms, which are mainly ignored by doctors in non-tropical countries. There are institutes of tropical diseases in which there are people who are very experienced parasitologists, but I would like to know very much how many doctors would think of sending a patient to these institutes unless he has been in the tropics? And what clinical experience do these parasitologists have? In all the chronic forms of the disease who thinks of searching for amoebae?

Whenever and wherever in the world the parasitologists have looked for amoebae in the stools they have found them—even in the Arctic Circle. It would be worth while to have these different statistics published from time