12-20 minutes per visit (including travelling). Few thoughtful patients or conscientious doctors would deny that this is totally inadequate, even as an average, for the practice of good medicine. Dr. Fry and his colleagues have sampled the existing system—the very “soup kitchen service” which I criticized at Swansea. For the sake of our patients and our own standards, may God forbid that future planning is based on this “five-minute medicine.”—I am, etc.,

East Preston, Sussex.

ALAN BUSSEY.

SIR,—Without discussion of the value of the idea of payment at the time of consultation by the patient we are dismayed by the introduction of this suggestion into the family-doctor Charter at this time. The National Conference of Local Medical Committees and the Special Representative Meeting of the British Medical Association both in June 1965 decided to continue to negotiate the Charter, to get it priced, and then to decide whether resignation was necessary to achieve just and reasonable terms and conditions of service.

We feel this new move can only complicate and delay matters.

We wish to express our full support for Dr. Cameron and his team of negotiators in their difficult and protracted task. Dr. Cameron asked for “just a little trust.” He is worthy of it.—We are, etc.,

C. M. TAGGART.

B. C. SMITH.

G. HARRIS.

G. P. WILLIAMS.

Shipston-on-Stour,
Warwickshire.

SIR,—Like perhaps not too few others, I opened my Sunday papers to-day to see the startling news that our great profession had “ratted” on its negotiators and the decision reached so painfully less than one month ago.

Do doctors honestly believe they are doing a good thing by adopting this resolution demanding a fee for a consultation? This can only lead to a head-on collision with a Government which is committed to a “free at the time” health service. It is unlikely that any Government which removed the prescription charge will agree to this, and, incidentally, it was not long ago that the removal of the prescription charge was official B.M.A. policy. As for the protest that this will lead to less paper work, we shall have more; every patient to receive, each time, a duly signed and stamped receipt, of which we shall have to hold a carbon copy for the benefit of the Inland Revenue.

What then? Do the Government or the doctors give in, and, if neither, does the Representative Body of the B.M.A. seek to force its view on the whole body of the general practitioners, which has given its answer, so recently, to the resignation issue in a more truly representative gathering?

Is it not time we sorted out who speaks for the profession and where policy is decided—what with the Representative Body of the B.M.A. and the Conference of Local Medical Committees, the public is, to say the least, confused. The profession to-day displays the image of a herd of cattle with the wind under their tails.

I, for one, wish to notify my support for the negotiations on the Charter as it stands. I reject the phony vote at Swansea and I hope that before too long the pages of your journal will be filled with others' letters who, like me, are disgusted with last week-end's news. Otherwise we shall see the end of a family doctoring of which I, for one, have been proud.—I am, etc.,

St. Blazey, Cornwall.

J. L. BARNARDO.

SIR,—Norway, a socialist country for many years longer than Britain, sees nothing wrong in making patients pay something at the time for general-practitioner and out-patient services. I well remember the surgeon who treated me in Odda two years ago saying, “We think it is not good that people do not pay something—otherwise they will abuse it.” His hospital was, of course, far ahead in equipment and modernity of any corresponding provincial hospital in Britain, and, in fact, in-patient treatment was free at the time.

I fully support the A.R.M. motion on patient contribution at the time of use and cannot believe that people who can afford cigarettes and beer and a weekly bet on the pools will be ground into poverty by contributing something to their own health.

My resignation stays where it is—in the B.M.A.'s hands, ready to be used as needed.—I am, etc.,

Southampton, Hants.

E. L. MCQUITTY.

SIR,—I am completely opposed to the proposal at the B.M.A. Conference that patients should pay at the time of consultation. Undoubtedly those who most need to consult us will be discouraged. The proposal is a frustrated and angry attempt to short-cut the problems faced thoughtfully and realistically in the Charter, which itself marks only a step to the full health-centre service which more and more authorities are favouring.

The way to deal with the demands on general practitioners is to train more general practitioners, prevent their emigration by better conditions of work, organize ourselves, our surgeries, and staffs to deal with the demands.

My impression is that heavy demands on surgeries is little to do with lead-swingers but is a lot to do with anxiety and overdependence by insecure people on general practitioners. It is part of our clinical business to know when and how we can help, and when we ought to push people back into their life situations. It seems to me thoroughly cowardly to erect a money barrier just as it is cowardly to be nice to patients' faces but pass vicious resolutions about them at conferences.—I am, etc.,

London N.6.

C. W. L. SMITH.

SIR,—Concern has been expressed that direct payments by patients might entail hardship to some. There is no need for actual money to pass at all. If the Government still wishes to be involved in the Health Service it could issue to each patient, yearly, vouchers or health stamps to an agreed amount, transferable between members of a

family. One voucher could be given for a consultation, two for a visit, and three for an out-of-hours or night visit. The doctor could collect these in a suitable envelope, or, in the case of stamps, affix them to a card made to hold 100. These cards could either be paid into a bank, or sent to local executive councils for the amount to be added to the quarterly cheque. The face value of the vouchers or stamps would have to be agreed—and, in addition, there would be a small, basic, capitation fee, also to be agreed.

This seems to be a quite simple and workable way of achieving what the R.B. asked for at Swansea.

If the Government does not wish to take part in such a rearrangement, then the administration and running of it could be undertaken by the body which is willing to underwrite Dr. I. Jones's B.M.A. Insurance Scheme, or by non-profit-making mutual insurance organizations.

I merely throw out this suggestion to demonstrate that an acceptable solution is by no means impossible or even particularly difficult.

If the Government ceased to be actuated by doctrinaire ideas, and took part in such a scheme, provisions for drugs and maternity services would be as at present. If it did not wish to take part, arrangements for provisions of drugs and maternity services could be planned perfectly easily.—I am, etc.,

Wolverhampton,
Staffs.

A. VICTOR RUSSELL.

Screening by General Practitioners

SIR,—The recent Report of the College of General Practitioners emphasizes the fact, already established, that over 90% of all incidents requiring a doctor's attention are dealt with entirely by general practitioners; the report even suggests that the hospital doctor sees as little as 2.5% of the disease in the community.

In the interest of early treatment and reduction of “the iceberg of unrecognized disease,” screening of the population is essential. If this work is not done by general practitioners it will be undertaken by the local authority and hospital services. Apart from very few dramatic emergencies, illness starts with symptoms apparently no different from those of trivial complaints. Recognition of the value of this essential part of the general practitioner's work might greatly reduce the very real and amply justified frustration increasingly felt by nearly all general practitioners.

It should not be difficult to estimate the relative cost of this initial screening as done by general practitioners, compared with its cost if undertaken by the hospital or local authority. The Minister, if presented with these figures, might well be induced to offer more realistic payment to general practitioners for this very important part of their work.—I am, etc.,

Redditch, Worcs.

C. L. POTTS.

Farmer's Lung

SIR,—There has been a regrettable omission in your editorial on “Farmer's Lung”

in your issue of 10 July (p. 59), which would be misleading to any reader who wishes to go back to the sources of reference. It was stated that the detection of precipitating antibodies against *Thermopolyspora polyspora* was reported by Pepys and colleagues in *Thorax* 1962.¹ Whilst this report dealt with the precipitating antibodies in farmer's lung against extracts of mouldy hay, the discovery that thermophilic actinomycetes such as *T. polyspora* and *Thermoactinomyces (Micromonospora) vulgaris*, and particularly *T. polyspora*, are an important source of antigens in farmer's lung was reported by Pepys *et al.* in the *Lancet* in 1963.²

The antigens in specimens of mouldy hay responsible for farmer's lung and present in extracts of *T. polyspora* have been termed "farmer's lung hay" (FLH) antigens. A clinical evaluation of the precipitin (FLH) test in farmer's lung has been reported by Pepys and Jenkins.³ This showed that an insidious onset of the attacks is not rare, as stated in your editorial. In 205 patients with farmer's lung, 49% had an insidious onset, 9% started with attacks of insidious onset and subsequently had the typical attacks coming on after some hours, 32% had typical attacks from the beginning, and in 10%, after a period of attacks with insidious or typical onset, attacks later came on more rapidly with a more marked bronchial component to the reaction. The clinical and serological findings in the patients in the different groups were comparable. Staines and Forman⁴ have previously reported that an insidious or typical onset occurred equally frequently. It is desirable that the different modes of presentation, other than those of the classical description, should be recognized.—I am, etc.,

M.R.C. Clinical Immunology Research Group,
Institute of Diseases of the Chest,
London S.W.3. J. PEPYS.

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2. —, Jenkins, P. A., Festenstein, G. N., Gregory, P. H., Lacey, M. G., and Skinner, F. A., *Lancet*, 1963, 2, 607.
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4. Staines, F. H., and Forman, J. A., *J. Coll. gen. Practit.*, 1961, 4, 351.

Computers in Diagnosis

SIR,—Sir Clement Price Thomas is quoted in your journal (17 July, p. 129) as saying: "There is even a threat that diagnosis will soon be possible by use of computer, surely a grim thought."

To some of us exploring these possibilities, and with some encouraging progress to report to date, this is not a "threat" but a promising possibility giving some hope that the average computer-aided doctor of to-morrow will be able to match the performance of the finest diagnosticians of to-day. Furthermore, to some of us the "grim thought" is that, because diagnosis to-day is limited by the knowledge that can be retained in human memory and which a doctor can recall in a particular situation, many possible diagnoses are missed completely or else delayed until the manifestations are sufficiently developed—a grim thought indeed.

Diagnosis, like prognosis and therapy, depends heavily on being able to recall rele-

vant manifestations to those observed or elicited during the clinical consultation and examination. A doctor will only recall well what he meets every week or month; he will not recall very well what he meets infrequently; he will not recall what he has never met or what is most recent and up to date. Moreover, he will not recall these possibilities with a lot of confidence—the confidence of not even knowing that he doesn't know. How else explain the confidence with which doctors were inflicting the most appalling damage in the administration of thalidomide? How else explain the high incidence of iatrogenic illness of patients in hospitals to which Sir Derrick Dunlop drew attention at a meeting in Edinburgh as recently as 5 April 1965?

Computers enable knowledge to be organized into them on a scale commensurate with what is known rather than what a single human mind can absorb. By telephone access they can make available a list of diseases whose syndromes are measurably similar to what has been observed as well as what symptoms/signs/tests should be sought in order to guide the doctor further in establishing a diagnosis. In doing this they will be drawing on much greater knowledge than any single individual can be aware of.

Diagnosis (prognosis and therapy) will be no less an art by this means, but it will be the art of making decisions on much fuller information. And, as Sir Ronald Fisher once remarked also in a Presidential Address (to the Royal Statistical Society), "the errors arising from too much information are not likely to exceed those arising from too little." The computer intelligently and properly used and understood is no threat; it will extend the clinician's capacity for refining decision by enabling him to take many more factors into account than he can possibly be aware of when relying on his own knowledge alone.—I am, etc.,

L. C. PAYNE,
Director, Medical Automation Unit,
University College Hospital, London.

Antibacterial Bacteriological Swab

SIR,—As one of the manufacturers of the pre-sterilized swabs referred to in letters from Dr. W. D. White and Drs. N. S. Mair and D. A. McSwiggan (24 July, pp. 229 and 230), we are concerned at the results, which suggest that these pre-sterilized swabs can have an antibacterial action.

We are carrying out investigations into possible causes and remedies; in the meantime we are withholding further supplies of these swabs until we and the Public Health Laboratory Service are satisfied that the problem has been solved.—I am, etc.,

C. G. CRAWFORD,
Technical Director,
Johnson's Ethical Plastics Ltd.
Slough, Bucks.

Autoimmunity and Rheumatoid Arthritis

SIR,—The recent paper by Drs. Margaret Turner-Warwick and Deborah Doniach on autoantibody studies in diffuse pulmonary fibrosis (3 April, p. 886) and the subsequent

letter by Drs. R. L. Ward and R. Stalker (3 July, p. 45) suggest the possibility that this condition may turn out to be one of the autoimmune diseases. The term "auto-immune disease" tempts one to assume a knowledge of the underlying pathogenesis, and would be much better replaced by the term "disease of altered immunity." This would be in keeping with the facts, and would not carry any assumption that the basic problem about such a condition had been settled. It would also, perhaps, encourage an inquiry into other evidence for the hypothesis of altered immunity.

The connexion between a chronic lung disease and positive tests for rheumatoid factor prompts me to report a retrospective study that I made while at the Whittington Hospital of the case notes of some 200 patients in whom a diagnosis of rheumatoid arthritis had been made.

I was mainly interested in the occurrence of ischaemic heart disease, but found that 18 of these patients (nine of each sex) had had an admission for an acute illness, regarded clinically and radiologically as pneumonia. These were compared with a random group of 33 patients (18 males and 15 females) of about the same age, and not known to be suffering from a chronic disease of altered immunity, who were admitted with an acute illness similarly diagnosed. Some of the comparisons are listed below:

	Rheumatoid Arthritis 18 patients	Non-rheumatoid Arthritis 33 patients
Average age of the group	65 (35–87)	66 (42–87)
Period during which admissions occurred	1957–64	1963–4
Average duration of hospital stay (days)	35 (16–75)	18 (7–29)
Number of patients with evidence of incomplete resolution on discharge, or at first out-patient follow-up	9	3

A few of those with incomplete radiological clearance had had negative bronchoscopies; three patients had developed radiological evidence of a pleural effusion (? sterile empyema), which in two cases was a further cause of ill-health, although in the main the patients were reported as being clinically well. The chest x-ray eventually cleared in those patients who continued to attend the hospital, but in one case it remained grossly abnormal for over a year. In the notes of those cases with a prolonged in-patient stay there was often a non-specific remark about "slow response to treatment."

There are a number of obvious reasons to account for the apparent slow recovery of patients with rheumatoid arthritis. Such patients are often anaemic; they are relatively immobile and respond less well to the manoeuvres of chest physiotherapy; and they are afflicted with the social problems of the chronic invalid, which may delay their discharge from hospital. In a retrospective study it is not always possible to evaluate these and other factors. However, it still appears that the reaction of rheumatoid arthritic patients to an intercurrent illness, such as pneumonia, is demonstrably different from that of patients without arthritis, and that their state of altered immunity is not only manifest by the occurrence in their blood of antibodies to normal body constituents.

This approach seems to me to be worth while pursuing, and likely to throw more light on the manner in which people differ in their ability to combat disease.—I am, etc.,

R. A. THOMPSON,
University College Hospital,
London W.C.1.