College research projects. I am in a well-organized, up-to-date group practice of four. We have a rota system. Despite these advantages we work a 74- to 80-hour week. In my opinion the publication of this report at this time was ill advised. To release it to the press before doctors generally had had time to assess it was, to say the least, misguided.

It should have been realized that the worst possible construction would be placed upon any adverse comments in it. A delay of one or two months, pending the completion of negotiations with the Minister of Health, would have been to the profession's advantage. Instead a disservice has now been rendered which is practically irreparable, conclusions having been drawn which in my opinion are inaccurate, hasty, and statistically invalid.

I agree that much of the general practitioner's time is taken up with trivia, but one of the qualities that makes a good general practitioner is his ability to sort out the serious from the trivial. Are we going to delegate this vital function of differential diagnosis to someone less qualified? But I agree that something will have to be done to aid in coping with this problem.

To analyse work load into actual time spent face to face with the patient is, of course, fallacious. How much time during an eight-hour day does an architect spend with his client, a colliery worker cut coal, or a solicitor spend in court? It is well known that physiologically a human being can work continuously and efficiently only for a period of a few hours without having a pause. Finally I would point out that the work load of general practitioners in South Wales is twice that of the south of England. How many practices in South Wales, the industrial north, or industrial Scotland took part in this survey? It is in these areas where the present problem is most acute.—I am, etc.,

Port Talbot.

D. HUBERT JONES.

SIR,—It is almost unbelievable that Dr. Fry and the College of General Practitioners should publish their report at the present stage.

In one blow they have, perhaps, succeeded in demolishing the general practitioners' case, which the Ministry have never succeeded in doing.

The folly of it is almost beyond belief, the motives impossible of deduction, the result probably catastrophic.—I am, etc.,

London S.W.4.

F. V. GRIFFITHS.

Certification

SIR,—I notice that the Blyth with Morpeth motion (*Supplement*, 24 July, p. 78), that all certification for N.H.I. purposes be abolished, was carried. I assume, therefore, that this is now the policy of the B.M.A., though I am very surprised at the lack of publicity over this quite radical departure.

I should like to suggest some ways of starting the ball rolling in this direction, and it is quite clear that our negotiators have no idea of the radical steps required, or they would not be so pleased with their reduction of four certificates a week.

Firstly, I think it is essential that the National Insurance Service should be completely separated from the National Health Service.

This I think is a fundamental error in the present National Health Service agreement. Separation of these two services would have a large and immediate beneficial effect on the Health Service. I do not mind patients coming in for trivial illnesses if they are worried about them, but I do object when they come in for trivial illnesses because all they want is a certificate. Furthermore, it would greatly improve the doctor-patient relationship, and it would be quite clear to the patient that the doctor's job was to give him advice or treatment on medical matters and not just to dish out certificates. It would also improve relationships, as there would be no need for arguments about whether the patient was or was not fit for work, which, though uncommon in my practice, do take up a long time when they occur.

This is a practical proposition. There is no reason why certificates should not be issued by medical auxiliaries such as health visitors, who, in cases of doubt, could call upon the R.M.O. I am sure a health visitor is just as well able to say whether somebody has diarrhoea or the "flu" from the certification angle as is the doctor. The treatment side, of course, would remain with the doctor. It is these short-period illnesses which tend to take up unnecessary time in certification. For illnesses over two weeks in duration, if the patient found his G.P.'s advice conflicted with the R.M.O. he could appeal for a general-practitioner certificate.

It would be up to the Minister to make alternative arrangements for his National Insurance Service, but I think we must stand out and make it quite clear that we consider it no part of the National Health Service.—I am, etc.,

Newport, Mon.

MICHAEL WADE.

Remuneration

SIR,—May I have this opportunity of correcting a misquotation of my speech on remuneration to the A.R.M? (*Supplement*, 17 July, p. 66.) I am reported as saying that the remuneration of a doctor with a list of 2,200 patients should be not less than £3,000 a year net. The figure I gave was £4,000 a year net. This is, of course, a very conservative revaluation in 1965 terms of the income suggested by the Spens Committee for the average doctor, which income was fully accepted by the Government as appropriate in 1948.—I am, etc.,

Low Fell,
Gateshead-on-Tyne.

J. C. ARTHUR.

Abuse of the Service

SIR,—Last Saturday at 6 p.m. a patient, who had visited me earlier in the week and who was not responding to treatment for a sore throat, asked me to call. She had not reattended, nor sent a message before 10 a.m., as she had hoped it would get better. I agreed to visit that evening and was asked when I would arrive. I wanted to know why she asked, and she replied that she was going out for dinner that evening.

This morning at 4 a.m. I was called to a woman with "chest pain." On arrival I found the patient had attended the surgery before with premenstrual breast pain, which had been investigated, her chest x-rayed, and she had been advised. This morning she had recognized the pain as the usual one and had not even tried an aspirin for relief.

This type of abuse cannot be stopped by "educating the public," and I urge our negotiators to press for a complaints machinery with penalties, which can be used against that small minority of patients who misuse the Health Service.—I am, etc.,

London N.W.10.

R. LAW.

"The Right Word"

SIR,—In answer to the letter by Dr. T. P. Lineham, Jun. (17 July, p. 174), which was also the opinion of "Pertinax," that the general practitioner's name gave the wrong image to the general public in this age of free-for-all under the National Health Service, I do not think that his word "physician" is well chosen. Granted the word "physician" denotes the knowledge of medicine and surgery (according to *Cassell's Dictionary*), but the name implies to most of us that the practitioner has chosen medicine as his "raison d'être." However, in *Nuttall's Standard English Dictionary* "physician" is defined as "a doctor of medicine; one whose profession is to prescribe remedies for diseases and not to perform surgical operations." Unfortunately for my interpretation of definition it continues "a licentiate as well as member or fellow of the Royal College of Physicians," and most general practitioners have the L.R.C.P. as we know. Gunnar Björck (2 July, p. 7) uses the word continuously to describe all medical practitioners, translating from his Swedish tongue.

Let us keep "physician" as the definitive name for a medical specialist. Certain epithets are not outworn. Surely the general practitioners should be proud of the surgical half of their degrees, which the physician prefers to discard?—I am, etc.,

London W.1.

MARJORIE M. DOBSON.

Scared to Death?

SIR,—I was very interested to read the letter under the above heading (7 August, p. 363).

It would appear that a not unlikely diagnosis here would be fulminating meningococcal septicaemia or Friderichsen-Waterhouse syndrome. Practitioners who were working in infectious diseases hospitals in Great Britain during the epidemic of cerebrospinal fever in 1940 would have seen a few cases of this.

I saw well over 300 cases of cerebrospinal fever at the Cardiff City Isolation Hospital (as it was then called) in that year, and they included five admissions of the fulminating variety of the disease, all of whom succumbed within a few hours of admission; if my memory serves me correctly they were adolescent or adult, one being an elderly man in the 60's.

The outstanding features were the state of shock with multiple petechiae and ecchymoses

of the skin, post-mortem examination revealing massive haemorrhages in the suprarenal glands in all cases. Death occurred so rapidly that involvement of the meninges appeared to have no time to occur and in only one case can I recall the cerebrospinal fluid being slightly opalescent.

There is obviously in this syndrome an overwhelming bacteraemia, and in one case I was able to demonstrate diplococci in a blood film, at least half a dozen being visible in each field; these were easily identified and were not artifacts. Diagnosis is exceedingly difficult unless there is an epidemic of cerebrospinal fever at the time and the medical attendant is aware of this fairly uncommon syndrome. Confirmatory diagnosis by blood culture is much too late.

A letter appeared in your correspondence columns during 1941¹ describing what would appear to have been a fairly typical case of Friderichsen-Waterhouse syndrome occurring in the West Country and labelling it malignant measles. About six months earlier an article had appeared in the *B.M.J.*² giving a full description of the disease under discussion.

It would appear that this unfortunate woman was incubating a fulminating meningococcal infection on her admission to hospital, the extensive haemorrhages into the suprarenals causing her rapid deterioration and fatal termination.

It would be very interesting to learn whether there were any cases of cerebrospinal meningitis in the community at the time of this woman's death, the size and nature of the community, and the season of the year.

Only chemotherapy and deoxycortone acetate (D.O.C.A.) were available in 1940, and it would be of interest to learn whether there have been any cases of recovery since the advent of more potent bactericidal agents, cortisone, etc.—I am, etc.,

D. TREVOR THOMAS.

Public Health Department,
Penarth, Glam.

REFERENCES

- ¹ Baker, Audrey Z., *Brit. med. J.*, 1941, 1, 380.
² Hughes, J. F., *ibid.*, 1940, 2, 353.

Diet and Ischaemic Heart Disease

SIR,—I should like to comment on the paper by Dr. G. A. Rose and others (12 June, p. 1531).

In the United States we have just concluded the first phase of the National Diet-Heart Study, which involved several thousand men. Two years of intensive discussion and planning preceded the study. During these discussions consideration was given to the thought of studying patients who had had actual heart attacks. For several reasons such an undertaking was not approved. Among the reasons were the following:

(1) The statisticians advised us that a very large number of subjects would be necessary in order for findings to have any possible statistical significance.

(2) By the time a man has a heart attack there is a large probability that the nature of his pathology will be essentially irreversible regardless of what one may do; that is, one is dealing to a large degree with fibrocalcific

lesions which would have little likelihood of responding to diet. Another way of stating this is that if one wishes to evaluate the effect of diet upon atherosclerotic lesions the time to do so is many years before the lesion has become symptomatic.

I believe that I am correct in saying that the data presented by Dr. Rose and his collaborators have no statistically or biologically significant meaning. It is unfortunate that they may mislead many people.—I am, etc.,

LAURANCE W. KINSELL.

Institute for Metabolic
Research,
Highland-Alameda County Hospital,
Oakland 6, Calif., U.S.A.

Jaundice in Severe Infections

SIR,—With reference to the article by Mr. A. Eley and his colleagues (10 July, p. 75), reporting five cases of jaundice associated with severe infections, in some places it is commonplace. For example, I remember in Bulawayo, Rhodesia, not a malarial area, that many previously apparently healthy young African adults with acute pneumonia developed jaundice, and also in some the jaundice was seen before the physical signs in the chest developed. Clain and Gelfand¹ investigated a few of such cases without finding evidence for haemolysis or cholestasis.—I am, etc.,

R. B. WOODD-WALKER.

Barnet General Hospital,
Barnet, Herts.

REFERENCE

- ¹ Clain, D., and Gelfand, M., *Centr. Afr. J. Med.*, 1964, 10, 217.

Beds for the Dying

SIR,—One of the sad results of the shortage of beds at teaching hospitals is the break in the doctor-patient relationship which occurs when one of their terminal carcinoma cases becomes in need of care. It is very undermining for some of the patients, especially those in the younger age group, to find that when they have to be admitted into hospital because of increasing pain or necessity for nursing they must often go to another hospital without previous warning.

One such patient recently reached one of my beds. She was only 45 years old, and it was some time before the Emergency Bed Service could find a suitable bed. One realizes that it is absolutely essential to give priority to carcinoma patients needing treatment, and in whom there is a possibility of response, before these terminal patients. Wouldn't it be possible for them to be admitted into a medical bed as an emergency, as is done, for instance, with acute bronchitis, and if necessary be moved to a terminal home from the parent hospital? Or, alternatively, more use could be made of the waiting-list for these homes by almoners in co-operation with the relations before the need arises.

The present situation is one that general practitioners find distressing, and it might be that more cases would be sent to the teaching hospitals if this difficulty was overcome. Surely sometimes personal concern for the comfort of the patient is as important as

treatment of the disease. The hospital concerned in this case, and in others in which the problem has occurred before, are always kind and helpful in other respects, and it seems only the fear of a blocked bed which brings about such decisions. However, to the patients, their doctor, and their surrounding friends and relations the rejection at the end of the road seems especially unkind if it has been preceded, as it often has, by much kindness and care, and doesn't help the image of the hospital.—I am, etc.,

Dunoran Home,
Bickley, Kent.

BARBARA G. MORTON.

Image of Nursing

SIR,—It was surely not necessary to do a social survey to discover that the public image of nurses as "very overworked" (26 June, p. 1626) is bad for recruitment, nor that the Royal College of Nursing's emphasis on higher education must have the same effect.

It is true that nurses work very hard, but they have many compensations. Apart from the high esteem in which they are held (quite rightly) by the general public, nurses have many facilities for cultural and recreational activities, and they lead a life which is rich in companionship. They do not waste their time and energy in travelling to and from work, nor do they have to clean their rooms, do their own laundry, or cook meals. These points should be emphasized and would do much to offset the drawbacks inherent in the provision of a 24-hour nursing service.

Similarly every doctor knows that the Royal College of Nursing's policy of increasing academic standards to those of university level is deterring suitable girls from entering the nursing profession. Many who have the necessary qualities of character and humanism fear they are "not clever enough."—I am, etc.,

Edgware General Hospital, M. D. BABER.
Edgware, Middlesex.

Synovial Fluid in Gout

SIR,—Dr. W. P. U. Jackson and Dr. F. Harris (24 July, p. 211) have had the good fortune to examine synovial fluid from a patient suffering from hyperparathyroidism, hyperuricaemia, arthropathy, and calcification of articular cartilage. Such fluids are of particular interest for the light they may shed on the mechanism of arthropathy in these patients, who are candidates, not only for gout and "pseudogout" but also for arthritis secondary to underlying bone disease.

Their case report describes attacks of acute arthritis affecting, *inter alia*, the right hip-joint and a big toe. This would suggest that more than one mechanism was operating, for hip-joint involvement in classical gout (especially during the first five years) is exceptionally rare, while podagra has yet to be described in pseudogout. Unfortunately the crystals have not been positively identified in this case, and the suggestion that the joint fluid contained crystals of two different compounds must be very tentative.