Correspondence

Because of heavy pressure on our space, correspondents are asked to keep their letters short.

The Gillie Report

SIR,—Reading the Gillie report will confirm our belief that general practice is not a job to be done but a life to be lived. The total and continuing responsibility of a general practitioner, we are told, contributes to the essential concept of a family doctor, and the fact that he is responsible for finding his own deputy is an expression of his personal independence. I am certain that there will always be young, idealistic doctors with the sense of vocation to work the long and irregular hours, to forgo social and cultural activities, and then to give the extra 5% of their time to further study.

The tragedy of the situation lies in the failure of the country to recognize the sacrifice involved and to treat general practice as a way of life rather than as a job. Instead the way of life has been written into statutory regulations which control every aspect of a G.P.'s life and work. Should he fail to adhere to them to the letter, he is answerable to a service committee containing laymen who in their own lives acknowledge no such statutory obligations but demand, as a right, all the benefits of the 40-hour week and limited responsibility.

To attempt to produce idealism by regulation can only injure the professional conscience and sense of vocation which the Gillie committee consider the real incentive to good general practice. This, no doubt, explains why doctors are increasingly complaining about their "24-hour day," and in some cases evading it by the use of impersonal deputizing services.

If the community is to receive service of this high order it must at least recognize that medical service committees should be composed entirely of G.P.s and should only have to decide whether a doctor has conformed to the traditions of the profession. In this way it can be made clear that professional standards and attitudes are more important than formal conformity with regulations.—I am, etc.,

DAVID L. WILLIAMS.

Holywell, Flintshire.

SIR,—After reading your summary of the Annis Gillie report (October 5, p. 861) I am forced to conclude that the members of the Committee have never heard the old saying that "It is the last straw that breaks the ass's back." We are told that the family doctor is overworked and also that there is no hope of reduction in the size of lists. Yet at the same time we are given an almost unlimited list of extra duties which we should be prepared to accept. In my opinion, not a single

constructive suggestion has been made for the more efficient organization of general practice.—I am, etc.,

W. E. MCPHILLIMY.

Doncaster, Yorks.

Immigration and Infectious Disease

SIR,—From time to time outbreaks of infectious diseases are traced to immigrants or visitors who come into this country without any health check on the part of our immigration authorities. As you are aware, we place virtually no restriction on the entry of foreigners into this country, and demand from them no certificates of good health or evidence of protective inoculations against certain diseases, irrespective of whether such diseases are endemic in the area from which they come to us. As a result this country is often faced with major problems, not least of which is the introduction of large numbers of cases of tuberculosis from the Middle East and Pakistan.

I am writing this letter because of a glaring recent example which could have led to a major outbreak of paratyphoid, and certainly could have caused a vast amount of unnecessary work and expenditure. We admitted to our hospital a 4-year-old Iraqi girl who was taken ill in Bagdad some two weeks earlier. After treating her at home for some time, the child was taken to a hospital in Bagdad with a high fever and other symptoms which were suggestive of paratyphoid fever. This, in fact, was a provisional diagnosis made at the hospital and treatment was started accordingly. The mother, however, did not trust the local hospital and decided to take the child out and fly her to England (the grandparents living in Sheffield). In spite of her acute illness she was able to buy an ordinary air ticket and come on an ordinary commercial flight with her ill child. No one ever asked her about the child's health, and she had no difficulty in landing at London Airport. She then travelled by train to Sheffield with the child, and promptly brought her to the Children's Hospital, where she was admitted.

The provisional diagnosis of paratyphoid was still quite reasonable, and the child was accordingly isolated. Fortunately intensive investigations disproved that she had paratyphoid fever or other communicable disease, and hence no further action was necessary for the protection of the public. Had it been otherwise, all the contacts in the aeroplane and elsewhere would have had to be traced, inoculated, and so forth.

Are the authorities ever going to take reasonable steps against the admission into this country of persons suffering, or

likely to be suffering, from major communicable diseases?—I am, etc.,

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J. LORBER.

Abortion and the Psychiatrist

SIR,—Dr. R. F. Tredgold (September 14, p. 681) suggests that I wrote my paper to stimulate correspondence and that I could not possibly mean to be so dogmatic. Stimulation of correspondence may have been editorial policy, and in this instance it has been successful, but my intention was to put before the medical public data which I had collected over a period of 12 years and to draw the obvious conclusions. My interest in the subject was not inspired by prejudice or religion, though some might argue that a desire to find out the truth comes under the latter heading. Equally important was my reluctance to act on inadequate or false information, when by a persistent effort a reliable answer could be found.

Dr. Tredgold is, of course, right in saying that the law recognizes psychiatric grounds for abortion, but only in so far as the pregnancy would make the mother a "mental wreck," and much will depend on the definition of "wreck." Temporary and/or remediable illness of a neurotic nature, in my opinion, does not qualify.

My paper was mainly concerned with the evidence regarding the prognosis and predictability of puerperal psychoses, the psychiatric sequelae of pregnancy in the grossly unstable, and the risks of suicide. I reluctantly gave my opinion on the legal aspect in reply to Dr. Darby's letter to correct his erroneous interpretation of the law. Mr. Rhodes's analogy (September 21, p. 750) of malignancy following vaginal leukoplakia is not as relevant as he would have one believe. He states that 10% of these cases became malignant, and asks whether it is not justifiable to abort 10 women to prevent one suicide. His information on the number of pregnancies (wanted or unwanted) which end in suicide or serious and irremediable deterioration in the mother's mental state is surprisingly inaccurate. I have already stated that unmarried mothers are relatively immune, and this has been confirmed by a general-practitioner colleague who for 30 years has been medical officer to a home for unmarried mothers. Suicide is rarer in the pregnant than in the non-pregnant; serious mental breakdown is virtually unpredictable, and does not occur more frequently than one in a thousand live births and carries an excellent prognosis. Furthermore, the grossly unstable tolerate pregnancy remarkably well. The odds instead of being 10 to 1 are far outside the range of 1,000 to 1.

Dr. W. L. Neustatter (September 28, p. 807) must have read my paper with "funnel vision," in that he states it is "devoted entirely to that rather dubious entity puerperal psychosis." All the above facts are included as well as the psychiatric risks of abortion, and my clinical work does not exclude psychiatric

sequelae of pregnancy other than psychosis. He points out that I failed to quote Dr. Bernard Hart's communication to the London Medical Society in 1912. Apart from the fact that Dr. Hart's paper was delivered as part of a symposium on Monday, March 25, 1929,¹ unlike the other contributors (Mr. Eardley Holland and Dr. Parsons-Smith), Dr. Hart failed to supply any specific data. His remarks were of a general nature unsupported by facts, an example which, unfortunately, Dr. Neustatter follows in his letter.

The issue, as I see it, is that, in spite of all the psychiatric evidence to the contrary, some of my colleagues are still prepared to recommend abortion on psychiatric grounds. I presume that their conduct is largely motivated by the fact that the pregnancies are unwanted, for if they advised termination under similar circumstances for a wanted pregnancy then their conduct in the medical sense would indeed be criminal.

What psychiatric expertise is required to advise on termination of the unwanted pregnancy? The psychiatrist is less able to assess the socio-economic factors than the family doctor or the patient herself. I agree with your correspondents that advising on termination can be a disagreeable and distressing task, but it should not be the psychiatrist's job. He has been introduced into the problem (albeit in some instances willingly) to do a job which is really outside his field. If society wants abortion to be easier it should have the courage to campaign for it honestly and not exploit the psychiatrist, who, I contend, has no factual basis for being associated with the problem.—I am, etc.,

MYRE SIM.

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Birmingham 15.

REFERENCE

- ¹ Hart, B., *Trans. med. Soc. Lond.*, 1929, 52, 294.

Present State of Medicine

SIR,—Your leader of August 24 (p. 453) pinpointed the need for reform of the N.H.S. and B.M.A. Dr. J. G. M. Hamilton in his letter of October 19 (p. 994) suggests that "remuneration" was the main reason for what he aptly describes as the "fracas at Oxford." I would suggest that it was the "flash-point" which blew off the lid. It was only one of many underlying causes, for there had been a growing sense of uneasiness and unhappiness and frustration gathering in momentum—not only in the B.M.A. but in the profession.

At Oxford there was bewilderment and anxiety as to what should happen and how something could be made to happen to resolve the unfortunate situation which had become manifest. Your leader must have provoked a great deal of thought—as will Dr. Hamilton's letter. He calls for action on two fronts for the solution of one problem—the "streamlining and making more efficient the

profession's machinery for major pay negotiations." I agree with his two-front action, but would expect a much more exhaustive and penetrating inquiry than apparently he envisages.

I believe that with determination and good will two working parties—elected on the lines of the Porritt Committee but very much smaller in numbers—could be and should be set up expeditiously with cross-representation and working simultaneously because the deliberations of each may have an important and decisive influence upon the other.

I believe these working parties should be able to present their reports to the profession within six months. The inquiries are an urgent necessity and call for urgent action—they will demand vigorous, sustained, and enlightened effort with eyes and thought fixed firmly on the future.

These working parties will have many difficult problems to consider. Examples of these are the future role which each constituent body will have to play and how these can be dovetailed together into one grand all-embracing scheme; the election of representatives, with full powers, from all bodies to each other's councils; redefinition of "local" B.M.A. and other boundaries; reduced local representation on Representative Body; new methods of election to B.M.A. Council; considerable reduction in size of Council or alternatively the election by Council of its own executive committee, which would require to be given wide powers; methods of ensuring that the profession was fully and continuously informed in the modern idiom. These are but a few of the important problems which will have to be considered.

As a profession it must be conceded to our critics that we have not yet conditioned ourselves to the amazing changes which have overtaken us in the social and medico-political fields. Our organizations devised and evolved by our forefathers no longer measure up to the harsh realities of the time and day in which we live. This is a common cry indeed to-day from so many sources—Government, trade-union, churches, etc., and from many countries besides our own.

There is an increasing and clamant demand for reformation and re-thinking if the old loyalties are to be maintained and new ones sought. We need to evolve a new image of ourselves for ourselves. We are a strange brotherhood—individualists all—yet we have a common goal. We must engender and foster a greater resolve to find "a common charity" in the years ahead. Let us make the effort now lest the shadows lengthen beyond our control.—I am, etc.,

R. PROSPER LISTON.

Tunbridge Wells, Kent.

SIR,—I am pleased that you consider the attempt to form a General Practitioners' Association important enough to

be commented on, at length, in your editorial (October 19, p. 945).

The Ministry of Health has to be shown quickly and expertly how important the general practitioner is to the patient, and a new association which gains rapid support will achieve that aim much sooner than the existing committees which are top-heavy with consultants.

What has the general practitioner gained with the present arrangement? He has obtained conditions that discourage good practice, conditions that make him give a minimum of service to his patients and make him refer a large number to hospital because he has not time to treat them properly. The consequences are lowered status in the eyes of the public and limited value in the eyes of important bodies that decide incomes, which is borne out by the increasing gap in the incomes of consultants and general practitioners.

If the majority of the profession believe that general practitioners are unnecessary then let the present trend continue, go on investing more and more money in the hospital service and neglecting general practice, and in the foreseeable future patients will become material for a vast, efficient, scientific machine which will be much appreciated by robots but not by patients who live, work, and have a family and background about which the "machine" knows nothing. I am convinced that the patient needs and always will need an efficient general practitioner more than an extravagantly equipped hospital service. Who would protect the patient from the specialist?

My conception of an efficient general-practitioner service is one in which the family doctor himself does much more for the patient in the way of making his own diagnoses with the aid of hospital facilities, treating patients at home and occasionally in general-practitioner hospital beds when special observation is necessary, treating the anxiety state which responds so well to general-practitioner handling, and using specialists in a consultant capacity only and not to carry out treatment from beginning to end. To say that general practitioners cannot keep up to date is clouding the issue. I attend refresher courses regularly, and what keeping up to date means is trying new fashions which disappear within a year or two. What it should mean is using new methods that prove to be genuine advances after a year or two, and in my opinion the general practitioner working away from the cloistered scientific atmosphere of the new "machine" is in a better position to see whether a new treatment will be of genuine benefit to the patient. In this way I feel convinced the patient would have a better service, much more to his liking, and the cost to the Exchequer would be less.

To achieve an efficient general-practitioner service it is essential to have a system of payment which rewards extra effort and service. For this reason a General Practitioners' Association with