outbreak (Crawley Down) after referring to the Health Department file on virus diseases. The result of laboratory investigations is awaited.—We are, etc.,

C. R. PALMER,
D. M. RICHARDSON,
K. N. MAWSON.

Haywards Heath, Sussex.

Blood Donation

SIR,—On the morning of November 5 the B.B.C. broadcast an interview with a man who had given 100 pints (57 litres) of blood to the Transfusion Service. This gave me to think how generous these volunteers are, and an idea occurred to me that we could help ourselves much more than we do in this way. Everyone who has to undergo surgery except of a minor nature could donate a pint (570 ml.) of their own blood before their operation in case they should need it. If not needed then the blood could go into the blood bank. Where major operative procedures were contemplated would it not be almost obligatory unless otherwise contraindicated?—I am, etc.,

E. A. R. EVANS.

Wrexham, Denbighshire.

Present State of Medicine

SIR,—It seems obvious that the unanimous dissatisfaction of the G.P. is concerned with his whole existence in the present set-up in the N.H.S., and that a change must be radical. As this dissatisfaction is not apparent in the case of the consultants' service—consultants seem well satisfied with their terms—then surely we must aim at this well-tried and successful method of service and remuneration.

General practitioners must have their surgeries in hospitals. The out-patients are not used all day, and could accommodate several doctors at a time. All the ancillary help is there. We may keep our own patients as the consultants have theirs, and could do sessions in accordance with our numbers, and if we wished have private sessions at home. Visits could be made to our patients too sick to attend, and we should be paid for each visit. Subsequent visits for dressings and injections could be made by the district nurse or other qualified person. If patients on our list wish to see us privately, they may do so in the same way as patients may see a consultant. By working in a hospital community our postgraduate education would be a continuous process. Holidays and free week-ends could easily be arranged amongst our colleagues. If consultants can be provided with these facilities free, there can be no excuse for refusing them to the G.P.

Not until we are given these advantages will the standard and dignity of general practice under modern conditions of knowledge and investigation be fulfilled.—I am, etc.,

Prestwich, Manchester.

N. LAUNER.

Doctors' Pay

SIR,—In your leading article of November 30 (p. 1349) you say, "General practitioners, we may be sure, will want to be in close touch with their colleagues in consultant and hospital service and approach the Review Body as a united profession."

I would be very interested indeed to know whether this is in fact the feeling of most of my colleagues in general practice. The present urgent problems are entirely our own, and involving the consultants in them merely slows down the already ponderous progress being made. May I ask the Association to get on with the job of improving our lot? Many of us will remember being sold down the river in 1948 by the consultant's colleges, we would rather that they were not involved in the present crisis, particularly bearing in mind the fact that their method of remuneration has no connexion whatever with ours.—I am, etc.,

E. J. ALLAWAY.

Birmingham 17.

College of Psychiatry

SIR,—Reports in the medical press have engendered the belief that the R.M.P.A. has made a firm decision to proceed towards the formation of a College of Psychiatry. This is not so. The recent meeting in London was held in order to stimulate discussion and thought about the whole problem, not to arrive at a binding decision. Such a decision can only be reached after a postal ballot of the whole membership of the R.M.P.A. The next step will be to discuss whether the time is yet ripe to hold such a ballot.—I am, etc.,

DESMOND CURRAN,

President of
The Royal Medical Psychological
Association.
London W.1.

Gall-bladder Dyspepsia

SIR,—Dr. E. W. Sheaf's approach to dyspepsia (October 26, p. 1065) is still impregnated with the Morgagnian concept of seats and causes of maladies studied anatomically (1761). What needs to be remembered, however, is that the vagus nerve supplies many structures besides the digestive tract, and that irritation of any branch of it can be responsible for dyspepsia. Thus examination and investigation of the areas of its distribution is needed in all cases of dyspepsia and not merely of the gall-bladder in cases supposedly of that origin. It is no accident that the so-called gall-bladder picture is being questioned. The reign of pure anatomy is over; physiology reigns in its stead, and classifications like toxic, obstructive, irritative, etc., are scholastic after-thoughts, good for teaching and examinations but not for the stuff of practice.—I am, etc.,

M. GLASS.

Capetown, South Africa.

Collapse after Pethidine and Promazine

SIR,—Collapse of the obstetric patient following intravenous administration of pethidine and promazine has been described by Mr. A. G. Amias and Mr. D. Fairbairn (August 17, p. 432) and Mr. D. J. P. O'Meara (September 21, p. 749). Collapse after intramuscular injection is illustrated by the following case.

A primigravida, aged 17, was booked at St. Paul's Hospital, Hemel Hempstead; her expected date of delivery was March 3, 1962. The pregnancy was normal. At 39 weeks her blood-pressure was 140/90. She was admitted at term with a blood-pressure of 150/70. Pethidine 100 mg. with promazine 50 mg. was given intramuscularly prior to vaginal examination. Shortly afterwards she collapsed and became cyanosed; the limbs were spastic and the pulse imperceptible. Cardiac arrest did not occur. Oxygen was administered, and coramine 2.5 ml. and aminophylline 10 ml. were given intravenously. She was tilted head down and then she slowly recovered.

She went into spontaneous weak labour three days later. Artificial rupture of the membranes was performed after a further three days. Spontaneous normal delivery occurred. Discussion with the patient during the puerperium elicited no information about sensitivity to drugs nor to other substances.

During her second pregnancy she remained well until term, then the blood-pressure rose to 145/90. A week later the blood-pressure was 150/90, with slight albuminuria. Two days later the blood-pressure was 125/80; the albuminuria persisted. She went into spontaneous labour at the 42nd week and delivered normally, on May 25, 1963, a baby boy weighing 7 lb. 2 oz. (3.2 kg.). We did not have the pharmacological courage to repeat the pethidine and promazine.

Observers agree that intramuscular pethidine and promazine usually give the desired effects safely. The intravenous route can sometimes give dramatic and alarming results for many drugs. Dr. D. Waghmarae (October 12, p. 936) describes maternal collapse following intramuscular pethidine (100 mg.) with levallorfan (1.25 mg.) and promethazine hydrochloride (25 mg.). I have seen collapse of the non-pregnant female following intramuscular promazine given post-operatively.

Pharmacological research will presumably, in due course, give the answer and solve the problem; at present it remains as baffling and alarming as untoward reactions to aspirin, which may occur on first encountering the chemical. The practical obstetrical lesson from the recorded cases is that expectancy yields better foetal dividends than radical intervention.—I am, etc.,

IAN A. DONALDSON.

London W.1.

Schistosomiasis in the West Indies

SIR,—During the discussion at the clinicopathological conference reported in the *B.M.J.* of November 30 (p. 1392)