choice, may decide for similar reasons that his patient had best be dealt with by a gastro-jejunostomy or even by purely medical treatment. I have been forced to make such a choice in circumstances in which the gastric operation would perforce be performed by myself. It is impossible to discuss a question like this except on the assumption that both medical and surgical treatment will be of the highest order.

When, with this assumption granted, it has been decided that the treatment of choice is thyroidectomy, the preparation for operation, important though it may be, is straightforward. Admission to hospital is no longer necessary until a day or two before operation. Patients suffering from mild symptoms and signs of thyrotoxicosis can safely be prepared by means of iodine alone. Lugol's solution in the unnecessarily large dose of 5 minims (0.3 ml.) three times a day is usually given for a period of two to three weeks. The patient is then admitted to hospital and the operation performed almost immediately.

When, however, the degree of toxicity is moderate or severe, it should first be controlled by means of methyl thiouracil. The thiouracil derivatives have the disadvantage of rendering the operation of thyroidectomy more difficult in the occasional case. This disadvantage—a small one in comparison with the enhancement of safety which accompanies it—can usually be overcome by the administration of iodine for two to three weeks before operation. Some physicians prefer to combine the iodine in the pre-operative period with methyl thiouracil; some (as at New End) forgo the thiouracil for the final period and use iodine alone; others overlap the two drugs for various periods, giving at first methyl thiouracil alone, then a combination of methyl thiouracil with iodine, and, finally, iodine alone. Others administer thyroid as well. So far it seems that no advantage is attached to any one of these methods. All are excellent in their results, and it will be many years before any valid comparison can be made between them. Whichever method is adopted, the patient is usually out of bed in four or five days and out of hospital in from nine to twelve days.

There seem to be few contraindications to operation. Certainly auricular fibrillation is not one of them. In from 60 to 80% of cases the fibrillation ceases, almost always in paroxysmal fibrillation, as a result of thyroidectomy alone or of thyroidectomy followed by a short course of quinidine. Even congestive heart failure is no contraindication, though it may call for a longer pre-operative period, perhaps in hospital. The operative death rate in skilled hands is under 1%, the incidence of other complications is negligible, recurrence is of the greatest rarity, and a return to normal life and work almost invariable.

The use of radioactive iodine may well be the method of the future, but no useful purpose would be served in discussing it here. Even in centres in which it is available it is still in the experimental stage. It is not generally available in Great Britain. When it is, it will be beyond the scope of the general practitioner because of the special knowledge and equipment which it requires.

In no other disorder is the judgment of the general practitioner, with his knowledge of the background, character, and economic situation of his patient, of greater value than in thyrotoxicosis. It should be largely his responsibility to decide upon the best method of treatment. On the assumption that an expert thyroid surgeon is at his disposal, he will probably decide on thyroidectomy, after adequate medical preparation, as the best treatment for most of his patients.

A DIFFERENT VIEW OF THE TUBERCULOSIS PROBLEM

BY

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Nearly all those who have written in the lay or medical papers about the tuberculosis problem, as it exists to-day, have emphasized the need for more institutional beds and for more nurses to staff them. While everyone will agree that there is a shortage of beds and staff, and that there are long lists of sick and often infectious persons waiting for admission, it must not be forgotten that the provision of hospital and sanatorium accommodation is but one aspect of the matter in considering any truly comprehensive scheme for the prevention and treatment of tuberculosis.

A few contributors have mentioned what may be called the other end, or perhaps the beginning, of the problem. They have written of the housing situation and particularly of overcrowding. While agreeing with them, most of us on reflection would like to extend the idea to improving the whole environment of the people, whether in the home, school, office, shop, or factory. Many of the early triumphs of preventive medicine were won on the environment front, and there is still plenty to be done there.

Let it be agreed, then, that at one end of the situation we want more functioning beds and at the other end better environmental conditions, especially housing, not overlooking such matters as milk-borne infection.

Sir Robert Philip's Scheme

What is lacking is uniform and purposive control. That kind of control can be produced and maintained only by restoring the tuberculosis dispensary to its proper position in each clinical area as the directional centre of what the late Sir Robert Philip called many years ago a co-ordinated tuberculosis scheme.

It is to be doubted if many of the younger men and women practising medicine to-day, even those working in the tuberculosis field, have any clear conception of what the tuberculosis dispensary should be and should do. It is certain that many members of local health authorities, hospital management committees, and regional hospital boards have only the vaguest ideas about the whole matter, and yet they are the bodies that are supposed to be directing policy. Up to the appointed day there were areas with excellent schemes, and there are still some; but they were never numerous, and many more local authority units were content with poor or indifferent arrangements. In these latter it will be found that the dispensary has become an isolated and degraded out-patient department, falling very far short of the kind of dispensary conceived in Philip's mind as long ago as 1887.

Below is shown how Philip defined the tuberculosis dispensary, and I am able to reproduce from my tuberculosis scrapbook the diagram which accompanied the description. Both pamphlet and diagram were given out to his classes in the University of Edinburgh after the foundation of the chair of tuberculosis.

Under the heading "Co-ordinated Tuberculosis Scheme—Edinburgh Pattern" the tuberculosis dispensary is described as "an institution for the detection of tuberculosis, and for the treatment and guidance of persons and households suffering therefrom. It is a 'reception house' and 'clearing house,' and a centre of information regarding

the prevention and care of tuberculosis." The functions of the sanatorium, the hospital, the colony, the open-air school, the tuberculosis care committee, etc., are then defined. If the diagram is examined it will be seen that the dispensary is the centre of the scheme—in fact, the sun of the tuberculosis solar system. Particular attention should be paid to the arrows pointing into and out of the dispensary. The former represent information, patients, suspects, and contacts coming into the dispensary, and the latter active search by the dispensary staff, including the physicians, for tuberculosis in the population generally by all possible means, together with domiciliary supervision, aftercare arrangements, and preventive measures.

Scheme of anti-tuberculosis measures: Edinburgh plan.

To-day I think we should be content to mark the circle entitled "Hospital for advanced cases" just "Hospital," and probably we should agree to replace the three interlocking circles marked "Colony" by some expression representing organized arrangements under the Ministry of Labour and the Assistance Board, together with voluntary bodies dealing with reablement, in addition to the actual colonies. With these trifling amendments the diagram presents the main idea to-day as well as it did when first drawn.

The Official Outlook

One of the important functions of a dispensary (now called chest clinic, in spite of the fact that tuberculosis affects other systems besides the respiratory) is the selection of cases for treatment. If this is done properly there should be some fairly substantial saving in institutional patient-days.

A recent Ministry of Health circular (RHB (50) 64) addressed to regional hospital boards makes the following statement.

"*Chest Clinics.*—Attention should be given to ways in which chest clinics can help to relieve pressure on institutional beds. A high standard of clinical judgment is necessary to avoid

recommendation of treatment for cases in which it is not essential and for which domiciliary care would suffice."

The circular goes on to emphasize the importance of avoiding the use of special treatment "when consequential complications may only protract the stay in the institution." It would be interesting to know how far institutional beds are occupied by and blocked by unfortunate patients who are the victims of ill-considered special therapy. It must be common knowledge that the readily acquired techniques of collapse therapy in its various forms have not always been accompanied by the judgment and wisdom which physicians (and surgeons) are expected to show.

The paragraph ends with a laudable exhortation to chest physicians not to neglect their duties in the spheres of prevention and aftercare. It runs, "Chest physicians will recognize that it is important to concern themselves *no less* with prevention and aftercare than with their clinical work; and that it is necessary to give *sedulous attention* to case-finding and the supervision of the tuberculous family, including *visitation in the home.*" The italics are mine. A chest physician who runs a dispensary as a second-rate and isolated out-patient department is clearly not doing these things, even if some semblance of the work is carried out by clinic nurses.

Speaking at a meeting of the Tuberculosis Society on January 21, 1918, Sir Robert Philip is reported (*British Medical Journal*, 1918, 1, 150) as saying: "Many cases of tuberculosis do not require residential treatment. Skilled surveillance at home or at the tuberculosis dispensary was sufficient." He goes on to define the cases likely to benefit from hospital and sanatorium treatment, including the rather special type of case suitable for colony treatment rather than prolonged "unnecessary and uneconomic" residence in a sanatorium.

Although 28 years separate these two quotations from authoritative sources, there runs through them the same emphasis on careful and skilful selection at the dispensary, chest clinic, or whatever we choose to call it. Once again it is from this central point, and this point only, that a properly co-ordinated scheme for the prevention and treatment of tuberculosis can be directed. To the layman and to many members of the medical profession a diagnosis of tuberculosis means automatic admission to the waiting-list for residential treatment. In fact, if this is not done, patients, their relatives, and the family doctor are apt sometimes to become resentful and distrustful. It is not surprising that local authority and hospital management committees think only in terms of institutional beds whenever tuberculosis is mentioned. It is someone's job to teach these bodies to revise their ideas and review the matter as a whole.

Unified Control

Two things follow. The tuberculosis dispensary must be restored to its proper position as the centre controlling a properly planned scheme in each area, and the direction must be under a medical officer of consultant status with real administrative ability. As has been stated already, there are still good and well-run schemes in Britain, but a large number of the men and women in charge of dispensaries lack administrative sense and good clinical judgment founded on mature experience. They need guidance, and, while capable of making a useful contribution, should not be left to drift along as many are doing at present. If this is not done, the exhortation quoted from the Ministry's circular can never bear fruit.

Finally, we arrive at the difficulty of dual control—in fact, King Charles's head again. The tuberculosis physician, as

I prefer to call him, is usually an officer of the regional hospital board. So long as he is working at diagnosis and treatment he is doing the board's work. When he is working at prevention, care, and aftercare he is doing duty for the local health authority under section 28 of the National Health Service Act, 1946. This matter was debated with much eloquence and enthusiasm at the Commonwealth and Empire Congress of the National Association for the Prevention of Tuberculosis in July, 1949. No definite decision was reached, but at the end of the meeting the impression remained that those with real knowledge of and deep sympathy with tuberculosis work strongly deprecated this dichotomy, and, moreover, foresaw that it would lead to disaster.

It will in the end have to be admitted even by the most obstinate administrative Civil Servant that the present arrangement, if such a term is admissible, or, to be frank, the present muddle, cannot be permitted to continue. There may be a difference of opinion concerning what body shall control the dispensary, but there surely must be agreement that we cannot continue to have two people at the ship's wheel, each wanting to go his own way, or possibly not caring which way he goes. No amount of talk about co-operation, co-ordination, and liaison—those sugary placebos of the Civil Service—can solve this problem. Above all, do not let us have any more joint committees. The works of the entire Health Service are cluttered up with committees.

Control must be in the hands of the regional hospital boards or the local health authorities, unless someone is rash enough to invent a new body altogether, which heaven forbid!

Many will feel that the local health authorities, as county councils and county borough councils, have had their chance, and on the whole have not done the job very well. Moreover, a dispensary (cannot we drop the misleading expression "chest clinic"?) must be attached to a hospital administratively if not physically. This being the case, let the regional hospital boards take control and come to terms with the local health authorities as best they may. This might need new legislation. It would certainly mean revision by the Ministry of paragraph 37 of Circular 118/47, which laid certain duties upon local health authorities.

Conclusion

Section 1(1) of the National Health Service Act, 1946, defines the duty of the Minister. "It shall be the duty of the Minister of Health to promote the establishment in England and Wales of a comprehensive health service . . . and for that purpose to secure the effective provision of services." The tuberculosis service is neither comprehensive nor effective, nor can it be so long as the present imperfect machinery is employed.

To sum up: (1) The tuberculosis dispensary must be restored to its proper position and function in each clinical area. (2) It must be adequately staffed and under the general direction of an officer of consultant status. (3) There must be unified control, preferably by the appropriate regional hospital board.

In his annual report for 1949 to the Kent County Council, Dr. A. Elliott, county medical officer, states that according to his estimate some 180 health centres would eventually be required in the county, but that the realization of such a programme at a possible capital cost of £18m. lies so far in the future as to make no real contribution to the work of the executive council.

TUBERCULOSIS AND THE NATIONAL HEALTH SERVICE

REPORT OF B.M.A. GROUP COMMITTEE

"The inadequacy of the present provision for the diagnosis, treatment, and aftercare of tuberculosis in this country is a national scandal which can no longer be viewed with complacency." So starts the comprehensive report prepared by the Tuberculosis and Diseases of the Chest Group Committee, which was recently approved unanimously by the Council of the British Medical Association. The Group Committee of 12 members, under the chairmanship of Dr. Peter Edwards, includes several medical superintendents of sanatoria and chest physicians in large centres, a thoracic surgeon, and a county medical officer of health.

The report, in discussing the problem of tuberculosis in relation to the National Health Service, draws attention to the 11,000 tuberculous patients awaiting admission to the 23,000 beds provided for the treatment of this disease. The development of a comprehensive plan is the more difficult because of the absence of any official figures on the optimum number of beds, nurses, and doctors, but the report outlines a policy and makes recommendations on the organization of the service, on the staffing of chest clinics and sanatoria, and on measures for the prevention of tuberculosis and the welfare of tuberculous patients.

The Problem Stated

Little detailed consideration is given to the tuberculosis service in the National Health Service Act, but certain general advice on the subject has been given to regional hospital boards by the Ministry of Health, and it is clearly intended that existing tuberculosis organizations are to be expanded into a branch of medicine dealing with all diseases of the chest. It is considered by the Group Committee, however, that tuberculosis will continue to be the main problem in the field of chest diseases for many years to come. In the past, as a problem of public health, it has been too much segregated from general hospital services. Many tuberculosis dispensaries have no x-ray equipment and no access to the basic services of a general hospital, and are inadequately used. The chest clinic, which will displace the tuberculosis dispensary, will be the centre from which the attack on tuberculosis is organized, but it must be linked to the general hospital, and it must also have the opportunity of applying to all forms of chest disease the principles of social medicine.

The prevention of tuberculosis and the social welfare and aftercare of the tuberculous patient and his family are the responsibility of local authorities under Section 28 of the Act, but they are inseparable from the clinical work of the chest physician, who must maintain the closest liaison with the medical officer of health, to whom he should act as consultant.

Organization of Clinics for Diseases of the Chest

Four principles are laid down for the development of future clinics for diseases of the chest:

- (1) The provision of a complete service comprising all aspects of chest and tuberculosis work.
- (2) Association wherever possible with general hospitals; occasionally such clinics may be sited within sanatoria, particularly in rural areas.
- (3) Provision of an efficient follow-up service and maintenance of close liaison with local general practitioners.
- (4) Provision for the education of medical students, practitioners, nurses, and social workers at suitable centres.

A large full-time clinic for chest diseases established in a general hospital will require its own permanent and specially trained auxiliary staff. In the smaller hospitals a part-time clinic, if adequately housed and equipped, may serve to upgrade the hospital and allow it to provide other specialist services previously available only at a larger hospital at a distance.

It is considered that each hospital region should be subdivided into smaller areas served by appropriately placed clinics. The