Correspondence

Care of Children in Hospital

SIR,—I have read and re-read with interest and profit the lecture given by Prof. Spence on the care of children in hospital (Jan. 25, p. 125). I am sure it will be of great interest and a stimulus to all who are engaged in this important work. Prof. Spence has given us much food for thought—so much indeed that it would be impossible to comment fully upon it within the space of a letter. One hopes that it will be a basis of much serious discussion and, if necessary, controversy among people who are interested in children's hospitals. I should like, however, to comment on one feature, and that is the "atmosphere" of a children's ward, so ably described by Prof. Spence. This masterly description should cause serious reflection and perhaps give rise to a sense of guilt. The state of affairs described by Prof. Spence is unnecessary but often only too true, and I would suggest that we, as doctors, are not entirely without blame. Too often have we looked upon the sick child as a patient presenting interesting clinical features requiring investigation and treatment. Too often do we tend to forget that while the child is in hospital the ward which houses him is his temporary home. The child is entitled, while in hospital, to have that feeling of security and affection which every home should provide. I feel that we, as doctors, can set an example. If the doctor will try to make the children realize that he is their friend and interested in them as human beings as well as patients, then the ward round might cease to be a distraction and become an eagerly awaited event.

There are numerous other ways in which the medical staff can contribute to a "happy atmosphere," provided they have an intimate knowledge of the working of a children's ward. Would it be too much to suggest that the medical student might acquire some of this knowledge by working on a children's ward during his training in paediatrics—by working I mean carrying out nursing duties under the ward sister for several days. I venture to suggest that in this way the future paediatrician would learn some valuable lessons in practical paediatrics.

Prof. Spence has pointed out the demands made on a nurse's time in carrying out the nursing treatment of small children, and has stressed the importance of an adequate nursing staff. As he rightly says, we do not realize sufficiently the extent to which an inadequate nursing staff may adversely affect the welfare of sick children. How can we expect a nursing staff—whose numbers are insufficient for the job—to nurse the dangerously ill child, nurse and comfort the fretful not-so-ill child, and nurse, comfort, and entertain the child in the convalescent stage of its illness? In his lecture Prof. Spence has shown one way by which the burden may be lightened. This has one disadvantage in that it is not always reliable. Many mothers of sick infants have other family responsibilities—especially the care of the young children—which they cannot lay aside easily. Could his suggestion be carried a stage further (or should I say backward?) and the help of expectant mothers be enlisted? I have in mind the mother expecting her first baby. Her family responsibilities are light, and the experience she would gain would be useful in the months to come. It might even be the means of avoiding a future case of "mismanagement and feeding error."

Another method of easing the burden on the nurses' shoulders would be to cater for the convalescent child by providing "diversional occupational therapy." This once fashionable term has fallen into desuetude. Let us revive it in the children's hospitals, but with safeguards. I would suggest that every children's ward should have the services of a teacher specially trained in bedside education methods. Such a teacher must recognize that her duty, as part of the hospital team, is the special care of the child in the convalescent stage and to render that stage as interesting, pleasant, and as profitable as possible.

No doubt, Sir, many of your readers have other and better suggestions than mine to render more tolerable "the daily rhythm of anxiety, wonder, apprehension, and sleep." To my

mind it is most important that the train of thought started by Prof. Spence should not be allowed to lapse. It is not necessary to wait for the structural alterations which most of us would like to see carried out. Let us remember that "four walls do not a hospital make"; it is the character and capabilities of each member of the staff which alone can provide the right "atmosphere." Let us never be satisfied with any improvement we make but always keep in mind that "achievement is but a milestone in the march of progress, the end of the journey lies ever ahead."—I am, etc.,

W. E. CROSBIE,
Medical Superintendent.

SIR,—I have read with great interest Prof. J. C. Spence's article (Jan. 25, p. 125) on the care of children in hospital, especially the question of nursing, as I am myself faced with an incredible shortage of nurses in the babies' ward, where there is barely one nurse for every seven ill babies. I was very anxious to try his method of getting their mothers to look after them and have surveyed the situation with that view in mind. I found that of eight bottle-fed babies who are in the ward at present, the mothers of four have five other children to look after at home, the mothers of two are ill in other hospitals, another had a partial gastrectomy here the day before, and the last baby's mother is suffering from puerperal psychosis. I envy Prof. Spence in being able to treat babies whose mothers can spare all that time for them, but I doubt that it is a practicable proposition in most children's departments.—I am, etc.,

Dartford, Kent.

JOHN LORBER.

Chemotherapy of Virus Diseases

SIR,—May I say that I agree with Dr. W. N. Leak's letter (Jan. 25, p. 160) protesting against the statement in the leading article of Dec. 7, 1946, that there is scarcely a hint that viruses are susceptible to chemotherapeutic attack? In the case of both vaccinia and smallpox viruses there is definite evidence that they are extremely susceptible to the action of potassium permanganate, which inactivates them even when diluted to 1:100,000. This extreme susceptibility to permanganate was described and illustrated in the Medical Research Council's Special Report, Series No. 98, 1925, and greatly interested the late Sir Andrew Balfour for the following reason. During an outbreak of severe smallpox in the Sudan the cases had been treated with compresses soaked in permanganate and applied to the skin lesions with amazingly successful result. The object of the doctors was to counteract any secondary infection, but Balfour saw at the time that something more than this must be involved to account for the beneficial effect. When he read the report in question and realized the high degree of susceptibility of smallpox virus itself to permanganate, Balfour was more delighted than I ever remember to have seen him. The pronounced viricidal action of permanganate on vaccinia virus *in vitro* ceases in the presence of glycerin. From this it would seem likely that the well-established value of glycerin in conserving viruses is due to the protection it affords at their weakest point—hypersensitivity to oxidation. Bacteria are far more resistant to permanganate than viruses.—I am, etc.,

Molesey, Surrey.

M. H. GORDON.

A Review of the Dietetic Factors in Liver Disease

SIR,—While admiring the painstaking effort and industry of Prof. L. J. Witts in summarizing the existing knowledge on the above subject, I was a little surprised to read some of his categorical statements on the clinical features of acute necrosis of the liver (Jan. 11, p. 45). He states, "Jaundice is intense." Surely one of the most variable features of the condition is the depth of the jaundice. Sometimes it is slight in the acute stage, and in general experience it is seldom as deep as in cases with obstructive jaundice, such as is seen, for example, in carcinoma of the pancreas or stricture of the common bile duct. It was perhaps for that reason that the old term "icterus gravis" long ago fell into disuse. This variability in the depth of the jaundice in acute liver necrosis was stressed by my father in his Lumleian lectures on toxic jaundice in 1931 (Willcox, W., *Lancet*, 1931, 2, 57). He maintained that the grave signs were produced by the liver deficiency, which he ventured to call

hypohepatism, and not to the retention of bile which is an associated feature. Nor did he, from his long personal experience of these cases, consider oedema and ascites as being found in this condition often enough to deserve mention; these two features would surely suggest cirrhosis rather than acute necrosis. I suggest that Prof. Witts is too rigid with his "rigid criteria" of the clinical feature of acute necrosis to convince those of us with experience of this distressing disorder.

Prof. Witts' definition of "toxic jaundice" is also confusing. Hitherto this term has been popularly used to group together jaundice due to toxic hepatitis of all kinds—chemical poisons, bacterial infections, various infections (including infective hepatitis), as well as that associated, for example, with spirochaetosis, relapsing fever, and other infections. They are all classified together because the jaundice in all these conditions is caused in a similar way, that is, by the toxic effect on the liver cells; and from the teaching point of view they fall naturally into one group. To confine the term "toxic jaundice" to cover only jaundice due to chemical poisons is heterodox and confusing; it is best avoided. Thus we may avoid a classification confusing alike to the student and to those with a wide outlook on toxic jaundice, who regard the condition as one of toxic hepatitis from whatever cause.—I am, etc.,

Windsor.

PHILIP H. WILLCOX.

Enlightened Self-interest

SIR,—Now that the Negotiating Committee is to be re-constituted it is pertinent to emphasize once again that the new Health Service affects the different groupings of the profession in varying respect and extent. In like manner certain of the principles laid down by the B.M.A. will be defended or conceded more readily by some sections than others. Why? Because they are or are not personally affected. The general practitioners are not only the very core of the scheme but are most radically affected. The question of the goodwill of practice, perhaps the most controversial of the principles, is almost, if not entirely, concerned with general practice, and it may be argued with force that on this and other grounds the voice of the general practitioners should have a preponderating importance. Whereupon, no doubt, the purist will object on the score that we are considering our own interests rather than those of the public we serve. The obvious reply is that the public will best be served by promoting that service which will be most efficient, and we believe—for many of us laying aside hypocrisy still dare to do—that the greatest spur to efficiency is self-interest.

The truth surely is that self-interest and ambition and desire for the public good are so interwoven that it is impossible to disintegrate them; nor are they, properly regarded and blended, in any sense antipathetic, but rather complementary and working together for the best. Whether the purists or the puritans like it or not, the entirely disinterested person is a very rare individual indeed—a fact borne out at medical meetings as well as elsewhere. It is right therefore that they whose whole future will be vitally affected by what is decided should have an equitable and proportionate voice in that decision. General practitioners will not be satisfied to have their case sponsored by, for example, the Presidents of the Royal Colleges, nor for that matter by those who are part-time consultants, part-time general practitioners, and who may look to become whole-time consultants. At such a crucial time the true general practitioner should be fully represented not only on the Negotiating Committee but on all the medical councils. Indeed it is not too much to ask that at all Divisional meetings the opinion of general practice should be sought and obtained by means of a special vote.—I am, etc.,

Wirksworth, Derby.

E. D. BROSTER.

System or Person?

SIR,—The older practitioners are more solidly opposed than those more recently qualified to the restrictive parts of the National Health Act. It is not fully realized that for seven years no doctor qualified after 1939 had a chance to treat a personal patient (private or N.H.I.); each patient was just a case under hospital or Service discipline, without consideration for his or her personality, or home, or family ties, or background, or responsibilities. I have yet to meet anyone

who wishes to be other than a personal patient. Those who have been in the Services are unanimous in their dislike of the impersonal outlook. "Oh, the treatment is all right but *you* just don't count, and nobody worries until you are half-dead." It is interesting that for the most part they do not blame the M.O. but "the system," though I have heard criticism of some of the younger men.

We are to be paid salaries to control certification. This can only mean that the State doctor will not be allowed to certify incapacity as he himself believes, right and for the patient's good but to a schedule dictated by a Minister-appointed bureaucrat interested solely in keeping the sick fund solvent. Further, it implies that the certificate of a private (non-State, personal) practitioner will, however honest and accurate, not be valid. Enter officialdom, exit humanity.—I am, etc.,

Newton Ferrers, Devon.

W. F. BENSTED-SMITH.

The Plebiscite

SIR,—The Council of the B.M.A. sent round a plebiscite to the members of the medical profession, and we held Divisional meetings to discuss this plebiscite and sent our answer, which was "No." The Council decided to abide by the decision of the profession not to negotiate with Mr. Bevan, but the Presidents of the Royal Colleges then got into touch with Mr. Bevan, and as a result the Council have now decided to ignore the plebiscite and to negotiate with Mr. Bevan.

Would it not save a great deal of trouble in the future if the B.M.A. Council would take their orders from the Presidents of the Royal Colleges and so save us the time which we have, unfortunately, wasted at our executive and Divisional meetings? I am sure that there is no point in having any further plebiscites, which will only have to be repeated until the Council get the result they desire.—I am, etc.,

Camberley.

LESLIE HARTLEY.

** Neither the Council nor the Representative Body has ignored the plebiscite. Both have recognized that the Minister's letter has changed the situation and have responded to that change.—Ed., *B.M.J.*

It's Happening Now!

SIR,—Had the Act provided a sound Health Service, with the interests of the patient at heart, the profession would have co-operated wholeheartedly and there would have been no need for a plebiscite about Regulations. Many who abhor the political structure of the Act agreed to negotiation about details, as they realized that to refuse negotiation would alienate public sympathy. To the lay Press the results of the plebiscite seem to suggest that nearly half the doctors are prepared to work the Act as it stands. Unfortunately the B.M.A. never put to us that straightforward question, or the Minister might have sent his representative along in a taxi for the second time.

The real meaning of the plebiscite is seen in the extraordinary number of doctors both in the public health service and the fighting Services who voted "No." Those in the public health service presumably chose that more sequestered life in preference to the hurly-burly of general practice, and can be expected to have a fairly intimate knowledge of State medicine. But instead of 100% voting for negotiation, more than a third voted against the newer and "better" State medicine. Again, had the Act been sound one might have expected the Services to be 100% in favour, with their freedom from having to send bills, collect bad debts, and their assured salary independent of work done, etc. The specialists (*vide* "Surgeons up in Arms," Dec. 21, 1946, p. 960) seem to have had their birthright sold for them by their autocratic Presidents, who would also appear to desire to sell the G.P.s' birthright for the same mess of pottage, and will have succeeded unless the B.M.A. takes an exceedingly firm line and in return for concessions to the Minister insists on amendments to the Act. The G.P.s' voting showed the interesting result that the older they got the more firmly they voted against negotiation about details while the structure of the Act remained unsound. Even the youngsters voted 925 for, and 1,415 against, but with increasing experience there were progressively more "Noes," until those in the oldest group—men who had seen their patients