National Health Service

SIR,—Having read no constructive criticism of the National Health Service I offer the following. At the plebiscite I voted "No," because I am against any form of compulsion, unless it be in war or for the maintenance of peace, law, and order, or in cases of unsound mind. Under the present Act of Social Security and National Health everyone is compelled to contribute a certain weekly sum, for which in return he will receive certain benefits. This should, in my opinion, be voluntary. The insurance company to whom premiums are paid should be a matter of individual choice, State or private.

A health service should be organized by the State for the benefit of those who pay their premiums and for those who are unable to pay at all. Consulting rooms, hospitals, etc., should be provided and staffed. Vacancies on these staffs, some whole-time, some part-time, should be filled by advertisement in the usual manner. Pay and conditions being good, there would be ample people to fill them. In addition, these State-controlled hospitals would offer accommodation for all, with three classes of luxury, those not in the State insurance scheme paying the usual fees and anyone wishing more luxurious accommodation paying the excess—the treatment in every hospital being carried out by its own staff. Private hospitals and nursing homes would remain as at present, as also would the public health services.

Medical teaching would be provided at the State hospitals and in the consulting rooms, in collaboration with the universities and colleges. Each doctor would be able to choose to work in private practice or part- or whole-time in some branch of the State Service.

I cannot in such a short space give a scheme in complete detail, but if it is worth doing it should not be too difficult. There is still time to start again and to produce complete medical facilities for all, based on the principles of freedom, and giving everyone the opportunity of being responsible personally for the care and future of himself and his family. It is only by giving such responsibility to the individual that the moral fibre of the country can be saved.—I am, etc.,

Southsea, Hants.

J. T. FURNIVAL.

Two Negotiating Committees, Past and Present

SIR,—The strongest impression I took away with me from the recent Special Representative Meeting was the lack of confidence shown in the Negotiating Committee. One resolution, which was carried, asked them to resign; others tried to impose terms of reference upon the new Negotiating Committee; and many more asked the new committee to report back frequently. What is wrong with the old and new Negotiating Committees? It is not the individual members that are at fault; it is the constitutional set-up that makes it unsuitable to carry out the functions invested upon it.

The B.M.A. has been recognized as the only body capable of negotiating on behalf of all shades of medical opinion. It represents the Royal Colleges, the consultants, medical officers of health, the Medical Women's Federation, and the general practitioners. Therefore the first Negotiating Committee, which had to discuss mainly the fundamental principles of the Act, should have represented the B.M.A. only and no other body. The committee would then have been bound to press upon the Minister the various resolutions passed by recent Representative Meetings with overwhelming majorities. Instead, we have had a Negotiating Committee divided among itself and giving the Minister the impression that the doctors were not united. The Negotiating Committee should have comprised men of talent and vision but nevertheless representing the majority view of the B.M.A. instead of men with violent sectional interests and conflicting views. How comes it that the Royal Colleges, which are already represented by the B.M.A., should have eight representatives of their own on such a body? Surely this is out of proportion to their political influence on the profession.

Then, a second Negotiating Committee should have been formed, similar to the present one in constitution, in order to negotiate with the Minister on Regulations and Orders. The men on this committee should be chosen for their sectional interests and would discuss details of administrative machinery

and conditions of service. But the fundamental principles of the Act would by this time have already been settled by the first committee, representing the B.M.A. only and, through it, the profession.

We have now reached a critical stage in our relations with the Government. The Minister has asked for negotiations to be started, presumably in accordance with the terms of our recent resolution. This resolution suggests very feebly that the Minister may agree during some stage of the negotiations to consider an alteration in the Act itself. It would be wrong of the Minister and the negotiating body to assume that this milk-and-watery resolution reflected the true attitude of the Representative Body. This body only gave way on the main resolution as a result of verbal promises made by the Chairman of Council. But the feeling of the meeting could not be mistaken. There was a determination not to compromise on its main principles and only to enter negotiations on the certainty (not the hope) that the Act itself would be amended.—I am, etc.,

Newcastle-upon-Tyne.

H. H. GOODMAN.

An 84-hour Week

SIR,—With your permission I would like to answer Dr. R. Dingwall Kennedy and several personal correspondents. It is becoming obvious that a large number of clinics will not be established for some years. During this period doctors' wives will be confined to their homes seven days and nights a week to answer calls. To-day many doctors are not providing a 24-hour service and are "getting away with it." Under the National Health Service scheme doctors, after an initial fine, will be directed by the Minister to find an outlet for their energies elsewhere than in the scheme. He will have the power, will use the power, and in my humble opinion will be quite right to do so, if we sign the contract.

My letter was written as a warning and contained a constructive suggestion. Half-day and holiday rotas can be worked out by the doctors themselves, but an emergency night service should be provided by the Minister. Among other things this will obviate the need of trying to get a domestic to live in. If we are to have planning let us plan properly, so that general practitioners and their wives may lead fuller and less harassed lives.—I am, etc.,

London, S.W.6.

G. ROSEMONT.

Cerebral Malaria in Great Britain

SIR,—Dr. P. H. Willcox (March 8, p. 310) has wisely stressed the importance of C.S.F. examination in individuals developing fever and meningism on return to this country from endemic malarious regions. On account of the frequency of malarial relapses it is also well to stress that in these cases malaria should first of all be excluded from the clinical picture before undertaking laboratory investigations for suspected concomitant infections, such as meningococcal meningitis. Negative blood films should never preclude the possibility of malaria, for among all its protean forms the cerebral type (except in children) most frequently evades microscopical detection.

A full-blown pyogenic meningitis, on the other hand, can always be bacteriologically confirmed, though investigation to this end frequently necessitates anaesthesia before cerebrospinal fluid can safely be withdrawn from a restless delirious patient.

Intravenous quinine is easily administered, and in cerebral malaria response is rapid and certain except when dangerous hyperpyrexia has supervened—a threat which is surely a further incentive to its prompt administration. Rapid subsidence of symptoms establishes diagnosis, or at least proclaims the dominance of malaria in the clinical picture.

Intravenous quinine is fraught with no particular danger, and where rapid decline of temperature and emergence from delirium or stupor do not ensue, investigation can then be directed to the cerebrospinal fluid without having lost valuable time—for time is a more urgent factor in the treatment of cerebral malaria than in any pyogenic form of meningitis. It should not be forgotten that a leucocyte count at the outset, when examining for parasites, helps in differential diagnosis.

I well recall the case of a young Frenchman brought to hospital in West Africa in 1943. He was febrile; restlessness and delirium had continued for 3 days before admission, and there were present

too all the signs of meningism, including nuchal rigidity and Kernig's sign. Blood films on admission were negative for malarial parasites, but despite this and during preparations for withdrawal of C.S.F. it was suggested that he be given intravenous quinine, 10 gr. (0.65 g.).

Half an hour after administration delirium had ceased, and lying comfortably in bed he spoke quietly and coherently and was curious to know what had happened to him. Examination of the C.S.F. was then carried out and meningitis excluded as a concomitant condition.

Malaria is a great simulator, and while not having had the opportunity of reading Dr. Walter Broadbent's letter (Jan. 4, p. 32) I conclude this fact was uppermost in his mind when approaching his case.—I am, etc.,

London, W.1.

A. C. LOVETT-CAMPBELL.

SIR,—In subtertian malaria schizogony takes place in the capillaries and not in the peripheral blood. If the parasites "swarm" in abdominal capillaries, cholera, dysentery, biliary colic, cholecystitis, pancreatitis, liver abscess, or even acute obstruction may be simulated. Similarly if the parasite "swarms" in the capillaries of the lungs, it may simulate bronchitis, pneumonia or pleurisy. It may even invade the capillaries of the heart and give rise to symptoms resembling myocarditis. The cerebral type is due to "swarming" in the capillaries of the brain, which become blocked by emboli of parasites undergoing schizogony.

In the communications published in your correspondence columns on this subject the type of parasite is not mentioned. If *P. falciparum* is absent and only the B.T. parasite is present, I should doubt the diagnosis of cerebral malaria as I understand it and look for some other cause of the cerebral symptoms.—I am, etc.,

Brookwood, Surrey.

H. M. STANLEY TURNER.

Retrodisplaced Gravid Uterus

SIR,—I have read with considerable interest the paper (Feb. 1, p. 169) on retrodisplaced gravid uterus by my old colleague, Mr. H. H. Fouracre Barns, but must quarrel with his conclusion that operative treatment of retrodisplaced uterus on account of abortion is not advocated.

In patient No. 39 Mr. Barns records the occurrence of three pregnancies in a patient in whom a ventrisuspension operation had been carried out. There is no record of the position of the uterus in the first two, but in the third it was certainly retrodisplaced, and following correction of this displacement a successful pregnancy occurred. From this it may reasonably be deduced that the ventrisuspension operation was unsuccessful and that the uterus was retrodisplaced in the first two pregnancies. When retroversion was eliminated the third pregnancy went successfully to term, and it seems probable that the same satisfactory conclusion might have been secured in the first two pregnancies had anteversion of the uterus been ensured.

In his case No. 42 spontaneous anteversion of the uterus following pessary treatment at the twelfth week was unsuccessful in preventing abortion nine weeks later. In the next pregnancy, however, the uterus was replaced at nine weeks and pregnancy proceeded to a successful conclusion. In this case the circulatory or other factors adversely influencing successful nidation in cases of retrodisplacement of the uterus were treated in the second pregnancy at a sufficiently early stage to allow of recovery and restoration to normal, whereas in the first pregnancy treated at twelve weeks circulatory factors had already caused so much disturbance that it was impossible for the pregnancy to continue.

In one of my own cases abortion occurred at 12 weeks in her first two pregnancies. On each occasion the uterus had been retroverted when she was first seen at eight weeks and had been manipulated and maintained in a position of anteversion by pessary, but, in spite of this, abortion had taken place about a month later on each occasion. Following this ventrisuspension was carried out and her third pregnancy went to term uneventfully. In this patient nidation had been so adversely affected by retrodisplacement during the first two months of the pregnancy that it was impossible for the pregnancy to continue. This is in contradistinction to the second pregnancy of Mr. Barns's case No. 42, but an individual variation in the capability of the pregnancy of tolerating adverse circumstances is found in other connexions than retrodisplacement.

While I agree with Mr. Barns's contention that habitual abortion may occur in patients with retrodisplacement of the uterus for reasons unconnected with this fact, I feel nevertheless that where abortion has occurred more than once and where

the uterus is found to be retrodisplaced there is a strong indication for ventrisuspension. As he himself has pointed out, circulatory abnormalities may interfere with the imbedding of the ovum. I agree that in the vast majority of cases retrodisplacement in the early months is compatible with normal pregnancy, and I share Mr. Barns's Service experience in this connexion; but nevertheless where abortion has occurred I feel that the factor of retroversion, which can be so easily eliminated, should be removed by operative means.—I am, etc.,

Inverness.

J. A. CHALMERS.

Thrush Vaginitis in Pregnancy

SIR,—Much has been written on the treatment of *Monilia albicans* in pregnancy by various authors, and a majority use a 2% watery solution of gentian violet. From thereon their methods of application and frequency of application, etc., vary very considerably. Several of the drawbacks to this treatment are: (1) the difficulty in adequately swabbing all the folds of the pregnant vagina; (2) the discomfort to the patient; (3) the very undesirable soiling of the patient's vulva, which secondarily soils her underclothing; (4) the difficulty in getting a cure by this intermittent method.

For two years now I have been getting excellent results by the following method:

The 2% solution of gentian violet is kept in a bottle with a neck not larger than 3/8 in. (0.9 cm.) in diameter (internal measurements). A "tampax" tampon is held against the open neck of the bottle, and the tampon and bottle are inverted and held in this position until the gentian violet has diffused almost the full length of the tampon, expanding it slightly. A Brewer's or Cusco's speculum is placed in the vagina and the large cheesy colonies of monilia are wiped away and the tampon inserted into the posterior vault of the vagina. This is left *in situ* for a week, when it is removed and replaced by another fresh and similarly treated tampon. On the average I have secured a cure after three weeks of treatment. The tampon's continuous supply of gentian violet constantly acts on any monilia present. The soiling of the patient (plus the operator and his equipment) is reduced to a minimum, for any discoloured seepage from the vagina is easily controlled by an ordinary sanitary towel worn by the patient.

With this treatment the itching and discomfort of the patient usually disappear within twenty-four hours, and a complete cure is usually obtained in two or three applications. This method lends itself very favourably to treatment in private practice.—I am, etc.,

Derby.

LINDSAY WATT.

Achromotrichia in Tropical Malnutrition

SIR,—During three years of service in the S.E.A.C. and with the occupation force in Japan I have seen a large number of nutritional anaemia cases. I am not including here those in whom anaemia was a feature of sprue syndrome. These patients were young Indian other ranks between the age groups of 20 and 30 years and almost all of them strict vegetarians. The presenting symptoms were breathlessness on exertion, progressive debility, and anorexia. They invariably ran a low-grade intermittent temperature. Diarrhoea was not a common feature until the end and the tongue was not sore. Rarely manifestations of other associated avitaminosis, like dry rough skin and pigmentation over the face, were present. C.N.S. was never involved. Haematocrit investigations done on some mostly revealed that the anaemia was of the hyperchromic megalocytic type.

In confirmation of what Capt. E. Roebuck writes (Aug. 24, 1946, p. 277), I may add that achromotrichia without any alopecia or looseness of the roots was noticed very often. Although I have not any statistical control studies I feel quite certain that the incidence of depigmentation of hair among such patients far exceeds that in the population at large. Another thing noticed was that more North Indians were treated in hospitals for gross degrees of anaemia although probably there are more vegetarians from South India in the Indian Army. They responded very well to high protein diet, iron, and vitamins, with liver administered parenterally. Blood transfusion was needed frequently and a common effect not often recorded was that the irregular temperature settled down immediately after it.—I am, etc.,

British Occupation Commonwealth Force,
Kure, Japan.

S. K. ROY,
Lieut.-Col., I.M.S./I.A.M.C.