surprise to see gapless jaws. Similarly, venous complaints were absent, although the Zulus suffer many infective and parasitic diseases. Their sole advantage is that of eating maize and other carbohydrates unrefined.

I think the remedy for us is to take food in as natural a state as possible—e.g., wholemeal bread and flour, salad, vegetables, and fruit, with fresh meat, fish, bird, eggs, and cheese, avoiding refined flour and ordinary sugar. To relieve constipation, some will need one to four tablespoonfuls of natural bran daily also.

Most patients accept this advice readily, with early benefit; they are merely waiting for our guidance. Health is still news, and there is truth in the saying, "We are what we eat." In my opinion we need to counsel this basic diet in and out of season. The corporate gains are capital and untaxed.—I am, etc.,

London W.1.

HAROLD DODD.

Snuff

SIR,—Professor D. F. N. Harrison's paper on snuff (26 December, p. 1649) combines a fascinating study of a social habit and a speculation on the aetiology of carcinoma of the upper respiratory tract. His statement that neoplasm of the nasopharynx is not more common in the negro than the white population may be correct in South Africa, but this is not so in all Africa, certainly not in East Africa. In Clifford's extensive series¹ more cases were believed to arise from the post-nasal space than from the antrum—9.5% compared with 8.7% of all malignant cases admitted to King George VI Hospital, Nairobi, between 1954 and 1958. My statistics of cases seen in Uganda during two years are incomplete, but I am sure I saw more cases of post-nasal tumours during that period than during 15 years here, though they were not as common as carcinoma of the antrum.—I am, etc.,

Rugby.

P. E. ROLAND.

REFERENCE

- ¹ Clifford, P., *J. Laryng.*, 1961, 75, 707.

Services for the Elderly

SIR,—Dr. R. Ll. Meyrick (16 January, p. 194) suggests that because the Lewisham Group is able to take old people into its general medical wards at short notice geriatrics as a specialty is unnecessary. Lewisham is certainly an impressive example of what can be done by general physicians who are ready to apply the techniques of geriatrics with the requisite enthusiasm and energy.

Unfortunately not all general physicians are as good at geriatrics as those in Lewisham. Geriatric units have arisen all over the country because the traditional department of general medicine has failed to cope with the problems of the elderly sick, especially those requiring rehabilitation and long-stay care. It is an almost universal experience that where a consultant physician, properly trained in geriatrics, is appointed to a hospital group the geriatric problem is transformed. The former chronic sick department, with a long waiting list, becomes an active medical unit; the turnover is doubled or trebled; and the waiting list is usually abolished.

That the general physicians of Lewisham have been able to do this themselves is greatly to their credit, but it would be premature to regard this as a precedent. It would certainly set the clock back to dismantle those departments of geriatrics which have made an effective contribution to the greatest medical and social problem of our time.—I am, etc.,

St. Helens Hospital,
Hastings, Sussex.

R. E. IRVINE.

Working Women Doctors

SIR,—There have been several recent surveys of women doctors qualifying at selected medical schools, primarily to ascertain the use that they have made of their medical qualifications.¹⁻⁴ In view of the present shortage of doctors the Medical Women's Federation decided to make a survey of all medically qualified women in the United Kingdom.

The survey was planned on a basis of the 25 regional associations of the Medical Women's Federation, so that the information obtained might be relevant to local staffing problems. Questionnaires were posted to all women doctors on the B.M.A. divisional lists corresponding to the M.W.F. regional association areas. These lists consist of the names and addresses of doctors of both sexes, whether members or non-members of the B.M.A. The Hereford Division, where about 40 women doctors live, was omitted owing to a misunderstanding. The north-eastern area, in which about 600 women doctors live, was used for a pilot survey six months before the main survey.

The questionnaire was aimed chiefly towards finding out how much work was being done by each woman doctor and how many wanted to do more. The term "session" was used to mean a morning, afternoon, or evening's work. A subsequent report will present a more detailed analysis and a study of those who did not originally reply.

TABLE I

Amount Worked	No. in Group
Full time	3,892 (42.1%)
Working 5 sessions or more	1,012 (10.9%)
" 4 " " fewer	1,351 (14.6%)
Not working	1,531 (16.6%)
Retired on account of age	1,240 (13.4%)
Spoilt answers and deceased	223 (2.4%)

In all, 12,774 questionnaires were sent and 9,249 replies were received—a response-rate of 72.4% (response-rates changed from 60.6% in Northern Ireland to 90% in N. and W. Wales). Table I shows the amount of work being done by those who replied. Over half were working either full-time or for more than half the working week. Table II shows the extent of the wish for work among those not fully employed: 1,139 (29.2%) wished either to do more or, if not working, to do some professional work. The wish to do more was more apparent in the

TABLE II

Amount Worked	No. in Group	No. Wanting Work
Working 5 sessions or more	1,012	109 (10.7%)
Working 4 sessions or fewer	1,351	395 (29.2%)
Not working	1,531	635 (40.7%)

groups with less work. Over 40% of the unemployed group expressed a wish to undertake some medical work. Only 898 (9.7%) of those who replied were neither working nor wanting work.

In this survey the number of unemployed women doctors (16.6%) is considerably lower than the 23% found in the survey of Birmingham medical graduates⁴ or the 25% unemployed found in the survey of Middlesex Hospital students.² It would seem desirable to assist the 1,137 underemployed women doctors who want medical work to find it, and also to explore the factors which prevent them and the 10% who are neither working nor seeking work from establishing themselves in their profession.

The Medical Women's Federation is grateful to those of its members and its secretariat who organized the survey and to the women doctors who replied to the questions. We would also like to thank the B.M.A. for its generous support.—We are, etc.,

JEAN E. LAWRIE.

MURIEL L. NEWHOUSE.

Medical Women's Federation,
London W.C.1.

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- ¹ Lunn, J. E., *Med. Care*, 1964, 2, 197.
² Kahan, J., and MacFaul, N., *Middlesex Hospital Journal*, 1962, 28, No. 4, 192.
³ Robb-Smith, A. H. T., *Lancet*, 1962, 2, 1158.
⁴ Whitfield, A. G. W., *ibid.*, 1964, 1, 374.

Rashes Due to Respiratory Syncytial Virus

SIR,—Your leading article on "Rashes due to Respiratory Syncytial Virus" (12 December, p. 1481) reports recent data suggesting an aetiological association between respiratory syncytial virus infection and a febrile exanthematous disease characterized by maculopapular rash. This adds another virus to the list of those aetiological implicated in rubelliform rashes (Coxsackie, E.C.H.O. viruses, reoviruses, and adenoviruses).

In this connexion I would like to recall that in 1957 my colleagues and I,¹ then at the University of Pennsylvania, isolated by inoculation into monkey-kidney-cell cultures of throat washings and faecal suspensions obtained from patients (mostly children), during an outbreak of erythema infectiosum ("Fifth disease"), a viral agent which produced multinucleate giant-cells and syncytium formation—with cytoplasmic inclusion bodies and alteration of nuclear chromatin—not unlike those induced by the measles virus and the respiratory syncytial virus. Paired sera from actual cases and from a few close contacts showed small but suggestive rises in complement-fixing antibodies against this agent. Our findings have been dismissed by several investigators, who considered that our isolate was merely a latent simian virus, picked up during blind passages in monkey-kidney-cell cultures. However, we were later able, in the course of another outbreak of erythema infectiosum, to isolate directly from a nasopharyngeal specimen in primary cultures of human amnion cells an agent which induced the same type of cytopathology as the former isolates, and which were shown by Dr. J. W. Frankel² to be antigenically unrelated to measles virus. From the same outbreak Dr. G. Henle³ isolated, on first passage in monkey-kidney cells, a similar cytopathic agent. A year later Wilcox and Evans⁴ inoculated into primary cultures of human

foreskin and uterine tissues faecal extracts from erythema infectiosum patients and observed cytopathic effects characterized by rounding of cells and formation of multinucleate giant-cells. This cytopathic agent was labile, as evidenced by the fact that it could not be reisolated from the original specimens after their storage for three weeks at -20°C . We experienced the same lability with our own isolates, which either got lost through storage or contaminated with true simian viruses during subsequent passages in monkey-kidney-cell cultures.

In several respects (nature of cytopathic effect, lability, particle diameter of about 100 m μ , absence of haemagglutinin) the agents isolated by us and by Wilcox and Evans from cases of erythema infectiosum (a mild, non-febrile erythematous and maculopapular rash) resemble the respiratory syncytial virus. On the other hand, no viruses bearing any analogy with other aetiological agents of various exanthems (Coxsackie, E.C.H.O., reo- and adenoviruses) have ever been isolated from unequivocal cases of erythema infectiosum. It thus appears as a distinct possibility, in view of all these facts, that the aetiological agent of erythema infectiosum may be biologically related to the respiratory syncytial virus, which, as was indicated in your leading article, may itself cause exanthematous disease. The fact that antigenic heterogeneity has been observed among various isolates of respiratory syncytial virus^{4,5} also suggests that this virus may be a member of a larger group of related agents causing illnesses of varying symptomatology and severity, ranging from mild exanthems to acute respiratory-tract infections.—I am, etc.,

GEORGES H. WERNER.

Société Rhône-Poulenc,
Vitry-sur-Seine, France.

REFERENCES

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Tuberculous Immigrants

SIR,—I support the strong demand for x-ray examination of intending immigrants, but we should not delude ourselves into thinking that the admission of only those immigrants with a clear chest x-ray would solve this problem. Dr. D. K. Stevenson¹ has drawn attention to the very serious situation in Bradford due to the large influx of tuberculous Pakistani immigrants. On the other hand, in other parts of Great Britain many of these immigrants come from rural communities where the incidence of tuberculosis is low and these susceptible tuberculin-negative reactors, often undernourished, encounter the disease for the first time in the factories or crowded houses they inhabit in this country.

For instance, in Wellingborough a small Indian community has sprung up since 1957. A mass radiography and tuberculin survey was carried out in November 1959 and a rough census revealed that there were approximately 65–70 Indians living in six houses in Wellingborough. These Indians had all emigrated from a rural area in Bombay State, and practically the

whole of the community had registered with one general practitioner. The latter coincidence was fortunate, as the doctor concerned soon realized the vulnerability to tuberculosis of these Indians, and referred many of them for chest x-ray, sometimes repeatedly in spite of previous negative findings.

From October 1957 to December 1959, 12 cases of tuberculosis were diagnosed in this small community—a morbidity rate of over 15%. All the disease was of recent origin, much of it was minimal, and many of the cases had had clear chest x-rays a few months earlier. In November 1959 the whole of the adult Indian population was mass x-rayed and Heaf-tested and any children were Heaf-tested only. No further case of active respiratory disease was uncovered in adults, but one infant with a violently positive Heaf had widespread glandular and early miliary pulmonary tuberculosis. Out of 56 Heaf tests there were 26 negative reactors (12 of which were children under 15 years of age), and these were all given B.C.G. A further 10 men failed to report for inspection of the Heaf tests. Thus out of a community in which about 17% (12 out of approximately 70) had contracted tuberculosis in a little over two years there was the surprisingly high proportion of over 40% negative tuberculin reactors.

None of these 12 cases would have been detected by a chest x-ray at the port of entry into this country. Apart from such obvious social factors as the provision of better housing, etc., the one measure that would probably have reduced the incidence of tuberculosis in this community would have been to give B.C.G. vaccination to all negative tuberculin reactors, either at the port of entry or to make it a condition of entry into this country for all prospective immigrants.

I stress that I am referring only to my experience with this local Wellingborough community, and that I accept that many immigrants that have settled in other parts of this country have come from places in India and Pakistan that have a high incidence of tuberculosis. Certainly all immigrants should have a chest x-ray, but it should be combined with tuberculin testing and B.C.G. vaccination of negative reactors.—I am, etc.,

Rushden Hospital,
Rushden, Northants.

O. E. FISHER.

REFERENCE

- Stevenson, D. K., *Brit. med. J.*, 1962, 1, 1382.

SIR,—On 4 January 1965 the Chief Medical Officer of the Ministry of Health wrote to all general practitioners confirming that they would continue to bear the initial responsibility for the medical care of tuberculous immigrants, as it was not practicable to x-ray them either before their departure or on arrival. The same week the Council of the B.M.A. appointed a fact-finding working party to study this problem. It will consist of a senior air or seaport medical officer, a chest physician, a radiologist, and a medical officer of health.

Whilst wondering why what is not practicable for our Ministry of Health is practicable for the authorities in Australia and some other countries, I would ask why not even one general practitioner has been invited to serve on this working party.—I am, etc.,

Exeter, Devon.

D. J. PEREIRA GRAY.

What is a Therapeutic Community?

SIR,—I was interested to read the letter from Dr. M. J. Heron (23 January, p. 250)

on our article "A Therapeutic Community in a Mental Hospital" (2 January, p. 47).

There is no point in splitting hairs over terminology but it does seem a pity that the opening up of any new technique in psychiatry arouses the anxieties and susceptibilities of some psychotherapists. The conception of a therapeutic community as developed by Main, Jones, and Martin is most important, but surely nobody could oppose modifying a therapeutic community which should take into account the particular interests as well as the limitations of the staff and patients of that community. However, a therapeutic community is nothing if not the opening up of communications for the benefit of patients as well as their therapists, and nobody should deny that there are many various methods of achieving the same goal. In any case, it ought to be borne in mind that an acute admission unit consists of a heterogeneous mixture of patients who are in hospital for short periods of time. How many analytically trained personnel are available for mental hospitals, which treat by far the greater number of the mentally ill? More direct techniques not requiring an elaborate training are therefore essential and seem to be useful in evolving a therapeutic community.—I am, etc.,

St. Francis Hospital,
Haywards Heath, Sussex.

S. JACOBSON.

Evolution of a Health Team

SIR,—I was delighted to read of the successful general practitioner–health visitor association in a South-east London suburb described by Drs. John Fry and J. B. Dillane and Miss M. M. Connolly (16 January, p. 181). Their encouraging conclusions as regards this sensible way of working together will be echoed by all practitioners and health visitors in Oxford. A similar successful experiment commenced in this city in 1956 and was followed by rapidly increasing numbers of further attachments until the completion of the scheme towards the end of 1963. Since then every practice has had its own health visitor, whole-time or part-time, according to need. None of the doctors or health visitors wishes to return to the former method of working. An interesting sideline of this development has been the increasing number of partnerships who now undertake their own practice child-welfare clinic, either in their own surgery premises, where these are suitable, or more usually at local-authority clinic premises.

Having achieved success over a period of seven years in the comparatively difficult task of attaching health visitors to practices, it was agreed in September last year to undertake a similar but speedier exercise with domiciliary midwives. In view, however, of the emergency nature of this work, it was decided to attach midwives in pairs to groups of practices according to the amount of domiciliary midwifery undertaken by them. As from the beginning of last October, all new bookings have been made on the basis of the attachment scheme resulting in a gradual run-down of midwives' geographical areas and a corresponding build-up of the general practitioner–midwives attachment scheme.

With regard to district nurses, an experimental attachment was started in May, 1963, and met with immediate success. According