health measure of the first importance," and doubtless any comprehensive medical service would be far more effective if backed by these other plans for social security. But the expected has happened, and the Government has not accepted the report as a whole. We are surely not going to refuse to take at any rate one step towards a better medical service, although all the public health measures are not as ideal as we could have wished.

Thirdly, for what reasons do we make the proviso about private practice? The only conclusions as I see them are these: (1) We think it will increase efficiency. As one member of the Council put it, State-provided service and private practice would act as a spur to one another. But attention to private patients can only detract from the time and consequently the efficiency which can be given to insured patients, will divide the allegiance of the doctor, and tempt him to give better service to the paying patient. If private practice is spurred on, then insurance practice is forced back. (2) We intend to give better service to paying patients. This has been dealt with by correspondents and leads to the assumption that the new medical service is handing out second-rate treatment. (3) We want to make more money. If this is the case, it is never stated in the discussions. We have every right to demand adequate pay, but do we demand private practice to increase our incomes? If this is so, then it is a poor opponent to put up against those who are striving for the best medical service that can be devised at the present time.—I am, etc.,

Oxford. A. DELISLE BURNS.

SIR,—There is one aspect of the proposed extension of complete medical services to all and sundry which I have not seen mentioned in any of the letters in the *Journal*. The question is, If the whole population is to be more or less "on the panel," how will the present number of doctors be able to attend them? As once a patient, previously private, becomes a "panel" patient his attendances increase greatly.

The general practitioner for years has been overworked with very little time for leisure, and if medical attention is to be popularized by being made available at little cost there will be no limit to the exploitation of the medical profession. What safeguards are we to have against this? I hope our negotiators will bear this very important point in mind. Would any lawyer contract to do all legal work necessary for a client for 9s. 9d. a year if litigation was as common as minor ailments are?

Most general practitioners will agree that panel work is extremely exhausting; that is probably why local B.M.A. meetings are poorly attended: exhaustion of the doctor is the real reason, not apathy, as has been stated. I agree with Dr. A. E. Moore (*Supplement*, Feb. 20, p. 27) that only by a questionary addressed to each individual practitioner can the real wishes of the profession be arrived at. Our negotiators should be instructed to make it quite clear that consideration must be given to the health and welfare of the doctors who are to run the scheme, and that conditions which cause gross overwork such as have been prevalent for many years will not be tolerated.—I am, etc.,

Blackburn. F. E. EDWARDS.

Venereal Diseases

SIR,—In the war against this scourge the Archbishop of Canterbury deplores that only the medical point of view is taken into consideration and that the religious aspect is not in evidence. When we look into the past, how the Church condemned unfortunates who through misfortune and ignorance became victims, is it any wonder that the meddling and self-righteous divines should have been ignored?

In the past 50 years, the time I have been in active practice in many parts of the world among many peoples, I have been disgusted by the utter lack of sympathy of the clergy of the Church, who have done their best not only to wrap themselves up in ignorance and intolerance of the difficulties of life but actively to prevent members of their Church from intelligent inquiry. When the late Lord Roberts over 40 years ago took some active precautions to mitigate disease in India the princes of the Church condemned him as harbouring vice, and demanded withdrawal. When a colleague of mine wrote a strongly worded article about the same time advocating precautions, his appeal was turned down, mainly on religious grounds. Fortunately, science, education, and reason have gone ahead, and people are not influenced by religious and superstitious threats, and divines have had to identify themselves with public opinion as they have had to water down and modify their assertions on religious belief generally.

This is an entirely medical matter and should be treated in a reasonable and common-sense way. Education has been lacking in this direction, and information on the most important human function we possess, its object and control, and in the matter of keeping sexually fit has been mainly obtained through secretive and "smutty" channels. Let us hope that light is at last coming through the darkness, stupidity, and prudery of the past, and that this terrible scourge will be recognized as an ordinary disease. Only on such sensible lines can we hope for success.—I am, etc.,

Southbourne. E. A. CHARTRES.

Scientific Freedom and Social Medicine

SIR,—Dr. Geoffrey Bourne (Feb. 20, p. 227) has vigorously attacked a problem which badly needs ventilation. It is of the utmost importance that in our medical planning we safeguard the professional independence of the experienced clinician, and allow him an effectve voice in the direction of the machine of which he is a part. Salaried medical men are usually too frightened of what might be the personal consequences to say what they feel on this subject. This is itself a serious criticism of the bureaucratic system, but probably an unjustified one. No sensible administrator regards the system under which he works as sacrosanct or will resent views expressed in good faith.—I am, etc.,

ELIOT SLATER.

Treatment of Cerebral Contusion

SIR,—Surg. Capt. Lambert Rogers (Feb. 6, p. 151) persuasively attempts to counter prevailing scepticism (to which the writer has long subscribed: *Brain*, 1932, **55**, 549) regarding the importance of cerebral oedema as a complication of cerebral contusion. There are, indeed, few head centres in this country which approve of the treatment he advises.

With regard to the clinical argument that his cases do better, it should be pointed out that to prove this he should inaugurate an accurate follow-up investigation on lines comparable to those described by Symonds and Russell (*Lancet*, 1943, **1**, 7) and Guttmann (*British Medical Journal*, 1943, **1**, 94).—I am, etc.,

W. RITCHIE RUSSELL,
Major, R.A.M.C.

Haemoglobinometry and Use of the Haematocrit

SIR,—We are glad to read the report to the Traumatic Shock Committee of the M.R.C. (Feb. 20, p. 209) and to note that serious attention is at long last being given in this country to the question of haemoglobin determinations. But the proposal to estimate the Hb concentration from a determination of the cellular iron is certain to lead to confusion. It has been shown by Barkan and confirmed by various workers, including ourselves, that the erythrocytes contain iron which is not in the form of Hb, and we have shown that the proportion of non-Hb cellular iron rises from 7% normal to as much as 40% of the whole in some anaemias.

In such circumstances we think it futile to remove the plasma before determining the total cellular iron. The plasma iron is negligible as an influence on the cellular total, and should be amply sufficient for general purposes to remove the supernatant plasma after centrifugalizing. The plasma remaining in the packed cells was demonstrated by one of us (C. E. J., 1932) to be about 10%, which would influence the total iron by about 1 part in 1,500. It is true that the committee emphasizes that the proposal is only an interim one, but interim methods have a habit of sticking. We consider that gas analysis with the van Slyke apparatus is far the best method of calibration.

We fail to understand the committee's opinion that a knowledge of the Hb of normal men would be desirable. Such information is already available. Many determinations by gas analysis have been done all over the world, and there is fairly good agreement that the male normal is about 15.5 to 16.0 g. %; in this country the only work published is by Jenkins and Don (1933). It was one of the largest gas

analysis determinations ever undertaken in any country, and its results agreed with the rest of the world.

The technical difficulties inherent in photometric methods are well known, but most of them require nothing more than a little common sense. But the difficulty of a permanent standard is serious, and for that reason we think that the flicker Hb-meter, using the Simmance-Abady head (C. E. J., 1930), has much to recommend it. Our experience of it agrees with Stokes's statement that there is better agreement between different observers using a flicker photometer than with any other form of visual photometer.

The committee deserves every encouragement in work which may end 20 years' stagnation, and we will conclude by recording our own opinion as to the ideal method of measurement. We believe that the only satisfactory instrument is the spectrophotometer. It is essentially superior to every form of colorimeter, including the Pulfrich type; there is no trouble with standards—once calibrated its permanency is absolute: its standards are no more than a wave-length and an extinction coefficient. Its cost is very great, but we firmly believe that sooner or later it is bound to be the standard instrument of every laboratory.—We are, etc.,

C. E. JENKINS.
Manchester. M. L. THOMSON.

A Member Resigns

SIR,—I think a considerable amount of the feeling of stultification experienced by members of the B.M.A. is due to two facts. (1) The Council exercises an arbitrary choice as to which resolutions shall be debated at the Annual Representative Meeting. This difficulty could be met either by choosing certain resolutions from each subject by lot or by allowing the A.R.M. to elect three of its members to choose which resolutions shall be debated. (2) We feel that there are a large number of members on the Council who have been there for years, who are automatically re-elected every time, and who are completely out of touch with the feelings of their members. It would be a wholesome reform if any member of the Council who had been on it for 3 years should be ineligible for re-election when his term expired. He would become eligible again one election later.—I am, etc.,

Colchester. M. E. LAMPARD.

*** Many letters on this subject have been received, but limitations of space make it necessary to discontinue this correspondence.—ED., *B.M.J.*

Mitral Systolic Murmurs

SIR,—Dr. William Evans, in his article on mitral systolic murmurs (Jan. 2, p. 8), has certainly put the cat among the pigeons. At first I thought that, after nearly forty years of continuous auscultation of hearts and trying to estimate the significance of abnormal noises, especially while on medical boards, the complete fogging induced in my mind by his article was the result of my own senility, though I was not conscious of any mental deterioration. But now that Dr. C. H. Ross Carmichael (Feb. 6, p. 172) "and several colleagues" also find themselves a little confused I feel happier.

All noises or sounds must be the result of some physical phenomenon: nobody at least can dispute that; and I feel that I am now old enough to demand from the cardiologists something a great deal more definite than I am getting. I do not like to be put off by being told that such-and-such a murmur is "irrelevant" or "innocent" and that its cause does not matter. Again, Dr. Evans states in two consecutive paragraphs in juxtaposition that "when the murmur is decidedly louder in the upright posture it is the innocent kind"; and then, "when a systolic mitral murmur becomes louder in the reclining posture the innocent nature of the murmur can be presumed." In other words, whether it is louder sitting up or lying down it is "innocent." Frankly, that does not make sense to me. By "mitral systolic murmurs" I should understand murmurs heard at the mitral area and caused by lesions of, or in the vicinity of, the mitral valve; so why drag in aortic stenosis and incompetence?

Because, in necropsies, Dr. Evans does not always find enlargement of the left auricle, he forbids us to use the term "mitral incompetence," thereby implying that there is no such thing *per se*, and without mitral stenosis. But a little further down the paragraph he says: "This sign [auricular enlargement] is absent unless some cause other than mitral incompetence is operating," thereby tacitly admitting that mitral incompetence does occur *per se*. Lastly, and to get down to brass tacks, how can a loud or soft organic systolic murmur (granted that it comes under my definite heading of "mitral murmurs") impinging directly on or incorporated with the first sound heard at the mitral area be caused by mitral stenosis? Surely, stenosis or no stenosis, there must be regurgitation of blood back through the mitral orifice. What else could cause the sound we hear? The blood is already in the ventricle before we hear it, the ventricle contracts, and unless the sound is caused by regurgitation back through the valve it must be caused by something else, and is therefore not a mitral murmur. If it *is* caused by back-rush through a damaged valve, then the valve is incompetent; therefore there must be such a thing as "mitral incompetence." You cannot have it both ways.—I am, etc.,

Stowmarket. H. S. GASKELL.

Periodicity of Relapses in Tuberculosis

SIR,—Your reviewer's quotation (Feb. 27, p. 255) from Dr. J. Burns Amberson on the need for promptness in the treatment of new tuberculous lesions if we "wish to accomplish maximum results at the most opportune time" reaffirms a main principle of value in the treatment of most diseases, but one often forgotten, and rarely applied as energetically as possible. Sometimes it can abort attacks, from respiratory catarrhs to cancer recurrences. As applied to relapse cases of tuberculosis its use would be greatly facilitated if there were any means of telling beforehand when any individual patient was in danger of a relapse (as by various methods of blood examination). Relapses have followed influenzal attacks often, but they may also have an intrinsic rhythm.

My recent study of over sixty cases of tuberculosis suggests that there is a cycle of activity in tuberculosis similar to that of the influenza-cancer cycle (Brownlee, 1919-23; Webster, 1938-42). Should this be confirmed by further research, follow-up methods would be facilitated (as, for example, the repeat examinations advised for mass radiography), and the principle of prompt treatment to new signs could be adopted more widely and more accurately.

Most of my personal observations have been in patients with tuberculous glands in the neck (*x*-ray and radium treatments), but a search in hospital reports and in the literature has shown a similar cycle in most types and sites. For example, an acute lung case (T. W., male, aged 36) showed four half-periods: onset 1914, July; worse in November; again in March, 1915; and July; and died in November (Powell and Hartley, *Diseases of Lungs and Pleurae*, 6th ed., 1921, p. 481). A more resistant case to begin with (Mrs. X, aged 29) showed a relapse after influenza at six periods, further exacerbation at one period, and death at the half-period (p. 484). Further studies are in progress. This preliminary note may stimulate others to search their records of relapse patients.—I am, etc.,

London, W.1. J. H. DOUGLAS WEBSTER.

Diphtheria and Diphtheria Carriers

SIR,—Few medical officers of health, one imagines, will fail to agree with the context of the letter by Dr. F. Lawrence Smith (Feb. 6, p. 171), nor with what appear to be his three most important contentions—namely: (1) That as a result of the progress of the national immunization campaign it "is not uncommon" to encounter "throats" where a "positive K.L.B. swab was a coincidence of no pathological importance." (2) That "it is imperative that medical officers of health should carefully investigate every case which is notified as diphtheria." (3) That in the absence of the precautions as indicated in (2), together with a deletion from the medical officer's register of such cases as were found to have been diagnosed on a positive swab but where the "diagnosis was completely at variance with the clinical evidence," the "Registrar-General's returns will continue more and more to give an erroneous impression of the influence, or lack of it, of immunization on diphtheria the disease."

Dr. Lawrence Smith's suggestion that the M.O.H. should on full investigation review and, if necessary, delete from his register notifications of diphtheria which he is satisfied are really diphtheria carriers is probably the best and most obvious in such districts where the M.O.H. has control of the isolation