influence their rejection of me for the appointment, but surely a political means test is an unwarrantable method of trying to assess a medical candidate for a purely medical post.—I am, etc.,

Stockport. W. E. BROUGHTON.

Mutual Confidence

SIR,—We read with interest the letter of Dr. N. J. P. Hewlings (Feb. 7, p. 269). We heartily agree with his views and feel sure that the big fear of all G.P.s *re* the future N.H.S. is that we cannot be sure how many of our colleagues will refuse to sign when the allotted day comes to join the Service. Dr. Hewlings's suggestions are very good, but we feel that they do not go far enough. We would like to suggest that when the time comes for signing the contract with Mr. Bevan—we presume there will be some form of contract—all medical men in all areas should meet, as we do for local B.M.A. meetings, and in the presence of each other join the Service or refuse to do so as they feel justified.

We—and I am sure many other doctors—having given a good number of years to the Forces, are just beginning to find our feet, and we feel that we dare not risk the possible loss of capital involved in the value of our practice or the compensation. Mr Bevan's strongest weapon is the fact that we lose all claim to compensation if we do not sign on the appointed day, and the only way for us to fight this weapon is for us all to publicly refuse service. By this means we will all be sure that we have sufficient backing to fight for better conditions. Our neighbours will not join for fear we have and we will not be forced to for fear our neighbours have.—I am, etc.,

J. H. BEGG.
Wroughton, Wilts. A. S. CAMERON.

SIR,—We think that the main issues of the controversy between Mr. Bevan and the medical profession are now clarifying. To us it appears that it is no longer a battle of the rights and wrongs of the scheme : it is essentially a battle of morale, for it is obvious that the vast majority of the profession are against the scheme. As we see it, unless some radical change occurs, the profession will vote 90% against the plebiscite and equally will vote 90% for the scheme in July. What is the reason for this ? To put it in a nutshell, the individual practitioner would vote against the scheme if he thought his colleagues would do the same, but unless he has faith in the integrity of his colleagues he will in the last resort vote for it. We suggest that some more binding arrangement should be made. In each area a document should be drawn up in which the local doctors solemnly pledge themselves to vote against the scheme. This document should be witnessed by independent persons and should be regarded as an absolutely sacred undertaking. There might be an escape clause releasing the signatories of the document from their pledge if less than 85% of the profession agree to do likewise. This should do away with these apprehensive people who wish to sit on the fence and who will at the last prejudice the opposition to the scheme. A list of those who sign these documents should be publicly displayed in the areas concerned and a copy sent to the B.M.A.

We feel that nothing less than the most energetic measures will meet the situation. The moral fibre of the country is not good, and to this the medical profession is no exception, for unless immediate action is taken to unite the profession, irrespective of the results of the plebiscite, Mr. Bevan's intimidatory tactics of divide and conquer will inevitably succeed. If the profession fails to rekindle the spirit of its ancestors, we are lost.

It may appear patronizing for young men who are not yet in the difficult position of most doctors with families to write in this fashion, but unless we are prepared to take risks we shall be in Mr. Bevan's parlour, and another bastion of liberty will have been taken. We do not wish to imply that we think the present state of affairs is perfect, but, as we have been at pains to point out, this is not the question. To put it vulgarly, it is "guts" that is needed.—We are, etc.,

J. W. MACLEOD.
D. H. H. WALFORD.
London, W.2. JOHN S. PRATT.

The Moral Issue

SIR,—A medical man in his professional capacity has and can have only one loyalty, and that towards his patient. By the law of nature and the recognized code of medical ethics, Christian as well as pagan, the doctor is bound to seek the welfare of his patient by all the means within his power exclusive of every other consideration. From time immemorial the Hippocratic Oath (*Encyclopaedia Britannica*, 14th ed., vol. 15, p. 198b) makes every medical man promise : "The regimen I adopt shall be for the benefit of my patients, according to my ability and judgment, and not for their hurt, or any wrong. I will give no deadly drug to any, though it be asked of me, nor will I counsel such. . . . Whatever home I enter . . . I will keep silence thereon, counting such things as *sacred secrets*."

It is quite clear to the medical profession that Mr. Bevan in the N.H.S. Act, 1946, shows himself jealous of this relationship. The preliminary draft of the National Insurance (Unemployment and Sickness Benefit) Regulations, 1948, newly made under the N.I. Act, 1946, for unemployment and sickness benefits, requires the insured person to "answer any reasonable inquiries by the Minister or his officers as to the advice given him by the medical practitioner." under pain of forfeiture of his sickness benefit. The Ministry of National Insurance betray suspicion of both doctor and patient ; in effect it will amount to sowing distrust between patient and doctor.

Mr. Bevan by the N.H.S. Act wants to assume *absolute* power over every doctor and surgeon in the land, and *absolute* mastery over every hospital and nursing institution he may at any time wish to seize. The N.I. Act regulations prepare the way to coerce doctor and patient to reveal to them and the whole hierarchy of officials the "sacred secrets" which no doctor may tell and no human being may be compelled to reveal—except where there is a danger to the patient himself (e.g., in case of lunacy) or to the community (as in contagious disease). Apart from this, no man has or can be given any authority to know such "sacred secrets." Both the N.H.S. Act, 1946, and the draft regulation under the N.I. Act, 1946, as they stand are therefore immoral. To carry out his obligations towards his patients, the doctor must be free from all interference from "higher authority" (including the paymaster, who regulates even the qualities of the medicines to be used), and the patient must have the right and the real opportunity to choose his own doctor whom he can trust implicitly.—I am, etc.,

Liverpool. THOMAS J. AGIUS, S.J.

Manipulation in a State Service

SIR,—When the time comes for the State to assume financial responsibility for all medical care, official provision will have to be made for, among others, patients requiring manipulation —the only branch of therapy suitable for delegation to medical auxiliaries as yet unprovided for. The number of doctors practising this art is so small that they cannot themselves deal with more than a fraction of all such cases. Indeed, there are said to exist, outside the medical and physiotherapy professions, some 3,000 persons in this country earning their living by giving manipulative treatment of one sort or another. This provides some measure of the amount of work done ; for, though a good deal of it may be done unnecessarily, this does not apply to all of it, as results prove. Since patients will be paying the State to defray the cost of all medical treatment they obviously cannot be asked to pay all over again for manipulation performed by unqualified persons outside the Service.

Grave danger may arise of the State being compelled by public demand to enrol and recognize irregular practitioners unless an alternative body exists to whom this work can be properly delegated. By virtue of their ethical stand and wholehearted collaboration with the medical profession the State will naturally turn to chartered physiotherapists to meet this demand. And the physiotherapists must close this gap, otherwise others exist only too ready to rush in to fill it.

It is thus imperative, in my view, that no time should be lost in teaching manipulative technique to physiotherapy students. The subject is in fact included in the syllabus, but is dealt with very cursorily at present at most schools. Indeed, before the war almost the only systematic teaching was that of Dr. Mennell

at St. Thomas's Hospital. May I urge all surgeons working at hospitals with physiotherapy training schools, and all medical officers of physiotherapy departments, to institute as a matter of urgency wider teaching on this important subject?—I am, etc.,

London, W.1. J. H. CYRIAX.

Rationing and Tuberculosis

SIR,—I heartily agree with Dr. Keers's observations (Feb. 7, p. 245) that during the years of rationed foodstuff sanatorium patients have been regaining their lost body weight at a much slower rate than comparable groups of patients did before the war, and I find too that clinically this slowing is accompanied by a slowing in the healing process, as evidenced by less rapid improvement in their sedimentin indices. I disagree with him, however, that there is any evidence that curtailment of meat and cheese are especially to blame.

It is illuminating to compare the performances of the average patient at Mundesley with those of the average patient at Tor-na-Dee over the same years. Columns 2 and 3 in the table below are the average gains in pounds of body weight during each twelve months in question (calculated in the manner described in Dr. Keers's article):

	Average Gain lb. (kg.)	
	Mundesley	Tor-na-Dee
1937	16·0 (7·26)	average 8·12 (4·08)
1938	16·2 (7·35)	
1939	20·3 (9·2)	
1940	5·7 (2·58)	6 (2·72)
1941*	11·8 (5·35)	1 (0·45)
1942*	15·8 (7·17)	10·5 (4·76)†
1943*	13·3 (6·03)	2 (0·9)
1944*	11·0 (4·99)	5 (2·27)
1945*	7·4 (3·34)	−1 (0·45)
1946	1·3 (0·59)	−½ (0·22)
1947	11·2 (5·08)	?

* Years of extra sugar at Mundesley. † Year of extra fats at Tor-na-Dee.

It will be observed: (*a*) Since food rationing began, patients at neither sanatorium have shown their expected pre-war rate of body-weight regain. (*b*) In 1940 both institutions showed a significant drop in the rate immediately following the onset of rationing. In 1940 I found that newly admitted Mundesley patients on wartime diet were on an average only 2¼ lb. (1.13 kg.) heavier at the end of their first six months. (*c*) At Mundesley from 1941 to 1945, thanks to the Medical Research Council, each patient was allowed an extra "experimental" 4 lb. (1.8 kg.) of sugar per week. This was taken by all patients in a fruit-flavoured drink between meals and supplied an additional 1.000 calories per diem over and above the ordinary diet. During this period I found that newly admitted patients on this regime regained their lost body weight at the same rate as pre-war new patients for the first two months (i.e., 1.6 lb. (0.73 kg.) per month), but fell off thereafter so that at the end of the first six months the "war diet plus sugar" patient was only 7 lb. (3.17 kg.) heavier whereas his "pre-war diet" counterpart had been 10½ lb. (4.76 kg.) heavier. (*d*) In 1942 arrangements were made for Tor-na-Dee Sanatorium to run a similar dietetic experiment with a special group of patients receiving an additional 1,000 calories per diem of *fats* instead of sugar. (*e*) In 1946 Mundesley was back on ordinary civilian diet (with of course the extra 2 pints (1.14 l.) of milk a day accorded to the tuberculous). Once again the drop in rate is significant.

I have three comments to make: (1) I agree with Dr. Keers that after each fresh "cut" in any commodity the rate of weight-increase fell badly for a month or two until patients accustomed themselves to make good with alternative foodstuffs.

(2) There is one inconstant factor, it must be emphasized, which tends to invalidate equally both Dr. Keers's results and mine—if viewed separately—and one which has hitherto deterred me from publishing my results until I could find a "control" series of figures which would be similarly influenced by this factor: and that factor—oddly enough—is the varying delay between diagnosis and admission to sanatoria. Since the beginning of the war this delay has grown from a matter of a very few weeks to peaks of five and six months before settling down to its present three to four months. While awaiting admission, usually in bed at home (where they are treated with all the family tit-bits), patients often regain a large proportion of their lost body weight. Consequently by the time they are admitted many are nearly back to their normal weight—a few are even over-weight—and they cannot be expected to put on weight anything like so rapidly as did their pre-war counterparts, who would have been admitted within a week or two of diagnosis when their body weight was lowest. The patient who is one stone below par regains his first half stone much quicker than he does his last seven pounds.

(3) Dr. Keers's figures have confirmed my belief expressed elsewhere (*Tubercle*, 1942, **23**, 10) that it is calories that count in combating tuberculosis and that the caloric value of the present civilian diet is inadequate for the tuberculous. I have gone so far as to hazard that the average daily requirement of the tuberculous patient is more than 2,500 calories. The best form in which additional calories should be administered is still an open question. Dr. Keers found that extra fats caused nausea (*Tubercle*, 1943, **24**, 8): few patients could go on taking them indefinitely. I found that sugar drinks could be imbibed without detriment to appetite or the capacity to enjoy full meals. Unfortunately at no time has there been a third experiment involving an extra 1.000 calories per diem in protein form; but there is still time so long as rationing remains with us.

It would be interesting to learn the experiences of any other sanatorium superintendents who hold the weighing machine in as high esteem as Dr. Keers and I do.—I am, etc.,

The Mundesley Sanatorium, Norfolk. GEORGE DAY.

Smallpox in Edinburgh, 1942

SIR,—Dr. C. Simpson Smith, in his paper on "Smallpox in Staffordshire, 1947" (Jan. 24, p. 139), states that "once again an outbreak of smallpox followed a confident diagnosis of chicken-pox by competent experts" and follows by mentioning four other outbreaks in which the same sequence of events occurred, including the Edinburgh outbreak of 1942. As far as Edinburgh is concerned he is completely in error, and the reference he gives (*B.M.J.*, 1944, **2**, 54) does not say so. The first patient coming to our notice was in cell isolation on admission to the City Hospital, and, though his rash had much in common with chicken-pox, there were certain elements which aroused our suspicions, and within two hours he was installed in the special smallpox isolation which had been earmarked for first cases in an outbreak. It is true that the above reference mentions that it was not till the rash of the patient was fully out that a confident diagnosis of smallpox could be made, but as he had been securely isolated from his arrival in hospital there never was the slightest suggestion that he infected others or initiated the outbreak. Furthermore, again quoting the reference given by Dr. Smith (a condensed version of a report I gave to the Fever Group of the M.O.H. Society), it is stated that the Edinburgh cases fell into two groups: (1) 23 institutional cases and (2) 13 city cases, of which five were direct contacts of other city cases. The source of infection of the institutional cases was never disclosed, nor was the association of these with the city cases, or of the primary city cases with each other.—I am, etc.,

City Hospital, Edinburgh. ALEXANDER JOE.

The Training of Specialists

SIR,—Sir Francis Fraser's masterly paper on the training of specialists (Jan. 24, p. 135) and the plan proposed are probably the fruit of years of careful thought and study, and it is only with great humility that one points out the dangers of the combination of rigid specialist training and the State-owned hospital. It is true that seven years of strict and orderly training will make the young specialist ready for responsible appointment sooner than the present haphazard system prevailing in this country, but, unfortunately all too often, there will be no job waiting for him when he finishes, and the period of waiting will creep on to ten, fifteen, or even twenty years, and an agreeable apprenticeship becomes an unhappy servitude.

The reason for this is not far to seek: the State-controlled hospital, unlike the E.M.S. hospital, *must* be economically run, and as regards medical staff this is done by reducing the chiefs