this noble profession should try to fight such a great issue on the narrow field that has been chosen. The State aim is obvious. Let us fight that, not quibble over the means which the State is employing. May I associate myself completely with Dr. K. Knowles's advice (Feb. 21, p. 357) and say fight *now* before Mr. Bevan can starve us out? After July 5 the spirit may be willing but the flesh will be weak.—I am, etc.,

Burton-on-Trent. R. LUNT.

Stand Firm

SIR,—The vast majority of the profession having now won a commanding position *vis-à-vis* the Minister, it is surprising and alarming to find so many of our colleagues—e.g., Dr. R. A. Nash (Feb. 21, p. 358) and others—seeming to cast doubts on the validity of that position and expressing the opinion that this and that principle for which we have been fighting are not after all worth fighting for. Some miss the point altogether; for example, one of my own correspondents, after airily dismissing three of our main contentions as unimportant, says of the abolition of goodwill: "Our strongest point—the Minister's remark about buying and selling patients—is sheer bunk."

Some think the Minister should be approached with suggestions of compromise, etc. Surely, Sir, such an attitude towards so intransigent a Minister is the height of folly and would merely delight him who is banking on cleavage in our ranks. It is devoutly to be hoped that the 90% will stand firm this time and that no approaches to the Minister will be made either directly or indirectly by the B.M.A. or by others apart from the B.M.A. Any such approaches for further negotiation must come from the Minister, for to his request for an answer Yes or No to enter the Service as it stands he has twice been given the answer No in no uncertain voice, and the objectionable parts of the scheme have been pointed out to him *ad nauseam*. He says our objections are unreasonable and our fears unfounded. Let him then expunge the objectionable parts and then we can talk again. Why does he not do so? Simply because he knows very well that these parts are fundamental to our freedom, which is what he is set on depriving us of.—I am, etc.,

Thame, Oxon. C. H. BARBER.

Basic Salary and "Squatting"

SIR,—While the basic salary is rightly or wrongly suspect in its political implications by the vast majority of the profession there are other grave objections to it that appear to have been overlooked. (1) The squatter, who has always been objected to by the established practitioner, in being subsidized will be paid at a very much higher rate per patient than the long-established practitioner. (2) The squatter is not required to submit any evidence of competence apart from a registrable one. In general he will be a young inexperienced doctor who has short-circuited the usual avenues affording experience—hospital appointments, assistantships, etc. The net result will be that the inexperienced in being subsidized will be encouraged to be an embarrassment to decent established practice and practitioners. At the same time there is no recognition by way of additional remuneration of approved experience in practice or for higher qualifications.

Witnessing this state of affairs, can anyone seriously believe Mr. Bevan when he claims that the idea behind the N.H.S. Act is to provide a comprehensive and better service for the whole community? Surely a better plea for any kind of supplementary remuneration would be additional capitation in recognition of approved experience and qualification to encourage a better and higher standard of service in general practice.—I am, etc.,

Fraserburgh. J. MACLEOD.

No Option

SIR,—In the *Supplement* of Oct. 14, 1944 (p. 83), you published a letter from me (then a wing-commander in the R.A.F.) in which I asked what the B.M.A. was doing or intended doing regarding the reinstatement of men who like myself had lost their private practices as a result of war service. In my own case, within six months of my recall to the Services in 1939 I had lost the whole of the income from my practice and over £2,000 capital I had invested in it up to then. For this I received no compensation, and on reverting to the retired list in May, 1946, I received a miserable gratuity of £175. With this I had to start all over again at the age of 46 and with a family of five children ranging from 1 to 15 years old to bring up.

After the hopeless failure of the B.M.A. Protection of Practices Scheme I can hardly be blamed for lacking faith in the integrity of my fellow practitioners.

In the recent B.M.A. plebiscite, while voting my disapproval of the Health Scheme in its present form, I did not agree to abide by the decision of the majority. If the scheme is forced upon us in July I for one intend to enter the Service, not because I approve of it, but because financially I have no option. And —as I remarked in my letter of 1944—there must be hundreds in similar circumstances to myself.—I am, etc.,

Diss, Norfolk. J. H. CULLINAN.

The Moral Issue

SIR,—The letter from Dr. Thomas J. Agius under the above heading (Feb. 21, p. 362) should be read by every practising doctor, as it portrays the appalling encroachment of the State into the "sacred secrets" of a man's life. These secrets up to now have been confided to the doctor only, and because the doctor up to now has also been called a friend. This bond which many doctors have with their patients must not be encroached upon or medicine will become a trade and be no longer an art.

"Discretion tested by a hundred secrets"—this was part of R. L. Stevenson's tribute to the medical profession, and he also wrote, "Generosity he had, such as is possible to those who practise an art, never to those who drive a trade." Sir, I would say that under State service we shall be driving a trade, and those of us who enter the scheme unamended will have destroyed the very soul of medicine.

Let us by every means at our disposal, whether it be by talks to our patients or lectures, but above all by a united front in our own district, convince the public that this is not the way to Beulah but to Bedlam.—I am, etc.,

Sidmouth, Devon. ARTHUR H. DUNKERLEY.

Nationalized Charladies?

SIR,—While in complete agreement with the views of doctors' wives on their importance to the N.H.S. as expressed in recent letters in the *Journal*, I should like to point out that there are quite a number of women practitioners who, if they unfortunately have no family relative to act as housekeeper, have to bear the double burden in many cases of running both their practice and their house, including surgery, accommodation, etc. Those of us who are thus situated will indeed welcome the nationalized receptionist-cum-charlady already visualized as yet another of the benefits to be conferred on us by Mr. Bevan. —I am, etc.,

Newbury Park, Essex. PHYLLIS C. MACKENZIE.

Brodie's Abscess

SIR,—Under this title Messrs. Stanley Scott and F. S. Preston (Feb. 14, p. 296) state, "It also occurs commonly after compound comminuted fractures." The case history of a patient developing an abscess in the tibia thirteen years after a compound fracture of that bone is reported. This raises a point of importance not only to medical historians but also to clinical teachers, authors, and statisticians.

There is a fascination in employing the name of the discoverer of a disease or of the first to describe a clinical entity. Unfortunately, as time passes, the original description is forgotten and there appears in medical literature and in bedside teaching a broader interpretation (or even a new one) of a condition once described in a masterly manner.

Benjamin Brodie read his first paper on this subject on March 27, 1832, and it was published in *Medico-Chirurgical Transactions* (1832, **17**, 239) under the title of "An Account of some Cases of Chronic Abscess of the Tibia." The clinical details are set out concisely and lucidly. He lectured on the subject at St. George's Hospital on Nov. 19, 1845, and this

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lecture was published in the *London Medical Gazette* (1845, **36**, 1399). The first patient in whom he recognized an undescribed condition was seen by him in 1824, but I find no record of him reporting this case prior to 1832; Scott and Preston did not state the reference when they wrote that Brodie had described "his abscess" in 1824.

It is quite clear that the latent abscess occurring at the site of a compound fracture long years after is not the entity described by Brodie, for there had been no open wound of the limb in his cases. The medical literature in our language is valued and we are proud of those whose names we associate with well-known conditions. If only for the sake of those who will read present literature in future days it seems important to realize what condition was described by the man whose name is associated with it. By this means the value of the original work is accurately reported from time to time and the memory of a great man is perpetuated.—I am, etc.,

London, W.1. ST. J. D. BUXTON.

Louse-borne Relapsing Fever in Persia

SIR,—Drs. R. I. Bodman and I. S. Stewart in their interesting article (Feb. 14, p. 291) claim that this disease had not previously been reported in Persia. They may be interested to know that it was encountered in Iraq and Persia on a wide enough scale as to cause much anxiety among our Forces in the campaign of 1914–18. The subject was reviewed at considerable length by W. H. Willcox and J. C. G. Ledingham in addresses to the Royal Society of Medicine on Jan. 27, 1920 (*Proc. R. Soc. Med.*, 1920, **13**, 59). In his opening address Willcox said that the disease was known by native practitioners as "recurrent fever" and by the Turks as "chronic fever," both typhus and relapsing fever being endemic and of greater incidence than enteric fever. Our troops were uninfected until their contact with the local population and Turkish prisoners. Louse infestation was appallingly common in the Turkish army and relapsing fever was known to be prevalent at Kut in the winter of 1915–16. The disease also occurred in the civil and military population of Bagdad in 1917, after its conquest by the army led by General Sir Stanley Maude. The following incidence of cases among military personnel was recorded (the total amounting to 1,883):

Year	British	Deaths	% Mortality	Indian	Deaths	% Mortality
1917 ..	20	—	—	196	8	4·08
1918 ..	110	6	5·5	1,557	126	8·09

Sir John Ledingham demonstrated the correspondence in the incidence curves for typhus and relapsing fever month by month from 1917 onwards which Drs. Bodman and Stewart notice again in 1946. The epidemic started in the last quarter of the year and attained maximal height in April, whereas in the 1946 epidemic January was the month of maximal incidence—a difference accounted for solely by variations in temperature and relative humidity of the atmosphere. On reading the accounts of the two epidemics it is interesting to note that they correspond in almost every detail with regard to symptomatology, complications, and the response to treatment with N.A.B. The mortality was about 1% for Arabs in 1918, being considerably less than for Indian and British troops. It was noted that cerebral relapsing fever might sometimes clinically resemble meningococcal meningitis. Jaundice was often a complication. There was evidence that lice are sometimes infective for both typhus and relapsing fever at the same time. For example, a medical officer contracted relapsing fever exactly 6 days after attending two cases of typhus, and there were other experiences from which it was concluded that lice can be vectors of the two diseases simultaneously.—I am, etc.,

Windsor, Berks. PHILIP H. WILLCOX.

Trichlorethylene in General Anaesthesia

SIR,—Since the introduction of trichlorethylene into anaesthetic practice in 1942, the two factors concerning this drug which have provoked more discussion than all others would appear to be (1) tachypnoea and (2) the necessity of employing only minute amounts of the agent. Concerning these two points, Dr. Gordon Ostlere (Jan. 31, p. 195) does little but reiterate what has been said already many times over.

He states, "The secret of a successful trichlorethylene administration lies in the employment of only small quantities of the drug," previous to which he has said that he uses as a vehicle for his vapour a 20% mixture of oxygen in nitrous oxide. There is, however, no mention of the effect of oxygenation upon tachypnoea and this to my mind is equally important. Using a 20% oxygen–nitrous-oxide mixture rapid respiration will indeed ensue if the amount of trichlorethylene vapour exceeds the minimal. If, however, the oxygen content is raised to 30% or more, then much greater latitude with the amount of trichlorethylene can be allowed and a more easily controlled anaesthesia obtained even though in the long run more of the agent may be vaporized.

Adequate oxygenation would appear to be an exceedingly important factor in the prevention of trichlorethylene tachypnoea, and since Dr. Ostlere's paper appears to have been written for the benefit of persons unaccustomed to using this agent I feel that this point should be stressed. I agree wholeheartedly with the writer when he refers to the use of minimal amounts of the drug, but may I make so bold as to add an amendment to his statement and say that "the secret of a successful trichlorethylene administration lies in the employment of only small quantities of the drug, together with a high oxygen percentage in the mixture"?—I am, etc.,

York. J. MCNAUGHT INGLIS.

Simple Test for Pulmonary Tuberculosis

SIR,—With reference to the letter under this heading (Jan. 24, p. 173) the monocyte–lymphocyte (m/l) ratio is recognized as one of several aspects of the differential count having special interest in tuberculosis, more particularly in relation to "resistance" ($m/l<1/3$) and to "spread" ($m/l>1/3$) of the disease. The idea is promulgated in the Houghton and Frimodt-Moeller indices, where monocytes and lymphocytes are regarded respectively as "liabilities" and "assets"; but in these indices the m/l ratio makes only minor contribution towards the final result, and Muller, who reviewed the literature, concluded that monocytic variations are relatively crude measures of the disease process and in the form of the m/l ratio are not diagnostic. In an established case of tuberculosis, serial haemograms (including the m/l ratio) can be helpful in assessing progress, but unfortunately the controversial significance of the monocyte and the multiphasic aspect of the disease (co-existence of recent and old-established lesions) preclude rigorous correlation with the underlying pathology and there is an inevitable "haziness" when we come to interpret the haematological data.

Classification in terms of an m/l ratio also implies confidence in the value observed, but the differentiation of monocytes and lymphocytes is not always easy and any error in this respect is doubled in the ratio. For example, an error $-x$ in the monocyte count leads to $m-x/l+x$ in the ratio, for what is lost to one is gained to the other. Although supravital staining has been used to improve differentiation, this difficulty still remains—in 1936 Dr. Heaf submitted identical blood films from three cases to each of 11 "competent authorities" and received the following range of reports: Case 1, lymphocytes, 12–29.5%; monocytes, 4.5–40%. Case 2, lymphocytes, 4–19%; monocytes, 4–16%. Case 3, lymphocytes, 36–65%; monocytes, 2–15%. The site and method of the puncture may also alter the picture, as monocytes can stagnate in the lobe of the ear.

Finally the standard error of the ratio which is of the order $\sqrt{m/l}$ (more nearly $m/l[\frac{1}{m}+\frac{1}{l}-\frac{2}{w}]^{\frac{1}{2}}$) must be considered. In a differential count of 100 cells ($w=100$), where $m=8$ and $l=24$, the true value of the m/l ratio is not necessarily $8/24=1/3$, but merely somewhere within the range $1/3\pm2$ SE—viz., between 1/13 and 1/1.7.

To summarize—not only is the m/l ratio largely indeterminate in relation to the general and special pathology of tuberculosis but it is also subject to considerable cytological and mathematical uncertainty. Hence it lacks scientific desiderata essential to any reliable diagnostic test and must be viewed with circumspection. Incidentally, bacteriological tests are just as "simple" to do and much "simpler" to interpret.—I am, etc.

Papworth, Cambridge. D. BARRON CRUICKSHANK.

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