who have shown how important are tactile, auditory, and visual conditioning in the initiation of the milk ejection reflex. These workers have drawn attention to the importance of a tranquil mind and co-operative attitude in lactating women. K. Haeger and D. Jacobsohn[19] investigated a group of women with milk-engorged breasts who were unable to feed their babies. They found that injection of 2 i.u. of oxytocin four to five days after parturition produced striking increases in milk yields in nearly the whole of the group. Further, most of the responding women continued to secrete and eject milk without further injections of oxytocin. It appears that this treatment may be highly successful when failure of milk ejection is due to the patient's anxiety about her capacity to feed her baby at the breast.

A GREAT P.R.C.S.

Lord Webb-Johnson, who died last week at the age of 77, will for generations to come be looked upon as the greatest administrator the Royal College of Surgeons of England has ever had. Long before his memorable presidency of the College he had made his mark both as a general surgeon of considerable skill and also as Dean of the Medical School of the Middlesex Hospital. It was largely through his unsparing efforts that the Middlesex was rebuilt, and it must have been for him a moment of intense satisfaction when that great institution was opened in June, 1935, by the Duke of York. Lord Webb-Johnson was never content to leave things to others, and no detail was too small or too insignificant for his notice. As Sir Gordon Gordon-Taylor points out in our obituary columns this week, he acquired a considerable knowledge of architecture and the practical problems of building, knowledge which stood him in good stead when the destruction of part of the College of Surgeons during the war necessitated plans for reconstruction. The Royal College of Surgeons of England to-day is indeed a monument to the man who for eight arduous and harassing years as President carried out his determination to make the College one of the world's greatest educational centres for surgery. Departments were established and professorial chairs were endowed for anatomy and pathology; a research department in ophthalmology was instituted; teaching for the primary fellowship was begun in the college laboratories; faculties in dental surgery and in anaesthesia were set up; and the College began publishing its own *Annals*.

This would have been enough to tax the energies of any one man, but Lord Webb-Johnson saw to it that the College was also a congenial social centre where medical men and their societies could meet and dine together in the magnificent new hall. The College gave him a great opportunity in which to give expression to the many sides of his richly varied character, and the south side of Lincoln's Inn Fields to-day bears out the truth of Emerson's saying that an institution is the lengthened shadow of one man.

CASUALTY CLEARING

As a result of the Lewisham train accident at 6.17 p.m. last December 4, 88 people died and over 100 more were seriously injured. It occurred after dark in dense fog and freezing cold, so it is not surprising that communications broke down. A report on it was issued last week by the senior administrative medical officer of the South-east Metropolitan Regional Hospital Board, together with replies from ambulance, police, and other staffs to questions on how the arrangements fared. "There was general agreement," says the report, "that hospitals concerned in the Lewisham disaster were at a serious disadvantage because of the absence of early information that the accident had occurred as well as any reliable estimation of the extent of it." A shortage of stretchers early on impeded the transport of casualties. The telephone lines, blocked by inquiries from anxious relatives, failed to provide adequate means of communication among the various hospitals and individuals dealing with the injured. The labelling of casualties was criticized, and so were the drugs and dressings that were available. Finally, overall control was not clearly established at first, owing to the appalling weather conditions and breakdown of communications.

It may well be thought almost impossible that the treatment of such a serious disaster at night and in fog could proceed without a hitch, and a tribute is due to all who did their best to help that conditions were not more chaotic. In a crisis of this kind avoidable mistakes such as leaving the dead on stretchers could add up to serious impediments. Some relatively small changes in the standard arrangements, it seems, would help to prevent trouble in future. More stretchers, for instance, might be readily available and more but less elaborate drugs and dressings. The mobile medical teams "were unanimous that all that was needed was supplies of morphine and simple shell dressings," while the suggestion was made too that the morphine should be available in "tubonic" form, since difficulty was experienced in administering it with the syringes and in the form provided. To aid telephonic communication it might prove helpful for hospitals to have lines not listed in the directory but known to the medical and public services.

In response to a circular from the Ministry of Health in 1954[1] all hospitals made or revised plans for dealing with major accidents, but it is a common experience for plans which look perfect on paper to go awry in practice. At Lewisham an emergency plan not only existed

[1] H.M. (54) 51.
[2] *Brit. med. J. Supplement*, 1958, 1, 171.
[3] *Brit. med. J.*, 1955, 2, 1144.
[4] Ibid., 1955, 2, 1562.

but had been overhauled only a month before the accident. A combination of fog, darkness, freezing cold, telephone breakdown, and a large casualty list is enough to upset any plan which can be made with the resources at present available for treating accidents. Whether these are sufficient has been raised from time to time. The Council of the B.M.A. has recently expressed the opinion that "in recent major accidents the arrangements for treating casualties have been satisfactory."[2] W. N. Leak[3] has claimed that general practitioners are allotted too small a part in these schemes, though they are often the first on the scene, especially in rural areas. And W. Gissane[4] has rightly argued from a unique experience at Birmingham that "the problem for solution is not represented by occasional disasters," for "each year, for the last 20 years, over 1¼ million injured have attended hospitals, and 10,000 have died in hospitals as the result of their injuries." Recent consultation between the B.M.A. and the Ministry of Health has shown that both the Ministry and hospitals throughout the country are alert to their responsibilities. But, as finance allows, should not more provision be made for treating the million or more people who receive hospital treatment for accidental injuries every year?

FIRST NEW HOSPITAL

The opening last week of the New Victoria Hospital at New Malden, Surrey, is a fine testimony to the spirit of Dr. F. B. Lake and his colleagues there. It is the first voluntary hospital to be established since the N.H.S. Act came into existence, and indeed the first new hospital of any kind to be opened in Britain since the war. The vision and enthusiasm which made this possible would have been admirable enough in earlier times; they seem the more so since bureaucracy began spinning a web round the medical profession. As reported last week,[1] a large private house was bought for £10,000 and converted to a fully equipped general hospital with 22 beds for £14,000. Future finance is to come from subscriptions by local members of the public, who have already shown their desire to have a hospital of this kind by subscribing handsomely to its creation. No charges are to be made to patients except for two or three beds in single rooms, for which a charge may be made to private patients. The local general practitioners will admit their patients and attend to them in the hospital, and a full consultant staff is available.

The old Victoria Hospital near by at Kingston-upon-Thames was, like the new, a general-practitioner hospital. As such, it was swept away in 1951 by the Minister of Health (Mr. H. Marquand) on the advice of the Ministry and the regional hospital board to make way for a gynaecological unit. The need for such a unit was undoubted; its advocates said it was urgent; but the need for a general-practitioner hospital was equally so, though it may have been impossible to state it in terms that seemed convincing to the planning authority. What gave a special importance to the action of the Kingston and Malden general practitioners was "their concern with the place of the general practitioner in the hospital life of this country,"[2] thus voicing what has been the consistent policy of the B.M.A. for many years. Many would agree with Dr. Lake,[3] who seven years ago wrote: "As larger hospitals become governed by remote control the smaller ones seem destined to cease to exist, and, since they are the only places where the two great divisions of medicine—hospital and general practice—meet and truly collaborate, this would seem to be a most retrograde step." Any measure to reverse this unhealthy trend is welcome, and the new hospital is a brave attempt to do so.

FOOD HYGIENE

In the recent correspondence on "Dirty Habits" in this *Journal* one writer complained of the foul smell which penetrated from the toilets of a café into the dining-room.[4] M. R. Candy[5] quite rightly pointed out that this was a contravention of the Food Hygiene Regulations, 1955, and that there might be a noticeable improvement in hygienic standards if members of the public would tell their medical officer of health whenever they see the regulations being flouted. Some who have strong views on this subject may feel that if they took this advice they would never be off the telephone to the town hall. But the regulations are gradually helping local authorities to improve matters and the fastidious customer to enjoy his food with a freer mind. By and large they give local authorities the power to see that caterers provide the premises and equipment needed for the hygienic preparation, storage, and serving of food, laying down that "no food business shall be carried on in any unsanitary premises." Any equipment which comes into contact with food must be capable of being cleaned and kept clean. The staff in premises where food is handled must "take all such steps as may be reasonably necessary to protect the food from risk of contamination," keep their persons and clothes clean, keep any cut or abrasion covered with a suitable waterproof dressing, refrain from spitting, refrain from smoking while they are in any room where there is uncovered food, and not wrap food, except uncooked vegetables, in newspaper.

Any food-handler who becomes aware that he is suffering from typhoid, paratyphoid, or any other salmonella infection, or dysentery, or any staphylococcal infection likely to cause food-poisoning, must forthwith notify the owner of the premises where he is employed, who in his turn must notify the medical officer of health. Sanitary conveniences in food premises must be kept clean and in efficient order, and must be so placed that no offensive odours therefrom can penetrate into any food room; and near every sanitary convenience provided for the staff there must be a clearly legible notice requesting users to wash their hands after using the convenience. All food premises, which must be kept

[1] *Brit. med. J. Supplement*, 1958, 1, 290.
[2] *Brit. med. J.*, 1951, 2, 784.
[3] Ibid., 1951, 2, 794.
[4] Bell, J. K. S., *Brit. med. J.*, 1958, 1, 1120.
[5] Candy, M. R., ibid., 1958, 1, 1303.
[6] Burton, J., ibid., 1958, 1, 1178.

clean and in good repair, should have a satisfactory water supply, and there must be wash-hand basins for the staff, with a supply of hot water, soap, and clean towels.

The regulations have now been in force for two years or so, and, though counter-hands can still sometimes be seen wiping their noses with their fingers before buttering a piece of toast or dabbing a plate with a cloth removed from beneath a sweating arm, the elementary facts about food hygiene are beginning to be more widely known. It is to be hoped that the "substantial efforts in publicity" described by Dr. John Burton[6] will eventually be followed by a substantial decline in food poisoning.

TREATMENT OF HOMOSEXUALITY

Of the tangled problems to which male homosexuality gives rise, one of the most direct interest to doctors is the medical treatment of it. The position is hard to assess for several reasons. Homosexuals differ greatly among themselves, particularly in the degree of bisexuality, and spontaneous changes along the Kinsey scale in the direction of greater homosexuality or greater heterosexuality are common. Moreover, many writers on treatment omit to describe in precise terms the psychosexual status before and after therapy, and use only vague ratings of improvement.

Changes resulting from treatment need to be considered under three headings: (1) direction and intensity of subjective sexual experience (impulses, fantasies, and dreams); (2) direction and frequency of objective sexual behaviour, and discretion with which it is practised; and (3) general well-being and adjustment. It is possible for changes to occur in any of these categories independently of the others, and even for improvement in one to be associated with worsening in another. Most reported series of treated homosexuals are small, sometimes (especially in the analytical literature) amounting to a single case only. Claims for successful treatment by leptazol[7] and testosterone[8] have not been substantiated, and the only chemical substances that may be beneficial are oestrogens—for the suppression of libido in selected cases. The main emphasis in treatment is on psychotherapy and social work. A. Ellis[9] found that 18 of 28 males treated psychotherapeutically were "distinctly" or "considerably" improved in terms of heterosexual adjustment. C. Allen[10] reported that of 16 cases treated privately 10 were cures, 4 social cures, and 2 failures. He found, however, that treatment was unlikely to succeed except when homosexuality was associated with shyness in the presence of women or with neurosis. These are important reservations, since many completely homosexual men have neither of these attributes. D. Curran and D. Parr[11] found no significant difference in the outcome of 25 private cases given psychotherapy and 25 not so treated. Isolated cases of change from complete homosexuality to complete heterosexuality by psycho-analysis have been reported, as by J. S. Poe,[12] but Anna Freud,[13] in reviewing the analytical literature, found that therapeutic pessimism prevailed. Among criminal homosexuals, the discouraging figures from the Cambridge survey[14] are to some extent counterbalanced by the results reported by workers of the Institute for the Scientific Treatment of Delinquency in probation cases.[15] In his interesting paper at p. 1323 of the *Journal* of this week Dr. J. A. Hadfield takes as his criteria of cure the loss of all homosexual desires and the establishment of normal heterosexual interests, and reports cure of eight patients, of whom at least three had no heterosexual interests before treatment. Dr. Hadfield does not use the Kinsey scale. Readers without analytical training are inevitably at a disadvantage in evaluating the early memories—for example, of difficult passage through the birth canal—which were elicited in the analysis of these patients. The paper by Drs. R. E. Hemphill, A. Leitch, and J. R. Stuart, of Bristol, on page 1317 briefly discusses treatment, but is of much general interest because it uses objective data and rates cases on the Kinsey scale, so facilitating comparison with other descriptive series such as those of R. Liddicoat[16] and Parr.[17] Since the Bristol series is composed of long-stay prisoners, there is a high proportion of offenders against boys. The number active both with adults and boys is surprisingly high, in contrast to the figures of Curran and Parr[11] and F. H. Taylor,[18] but the authors do not record how many were pre-pubertal boys. Eleven of the men studied by Hemphill and his colleagues had had medical treatment, and all reported some relief, though none experienced any change of sexual orientation.

The quotation from the Wolfenden Report with which Dr. Hadfield opens his paper is followed in the Report by a much more encouraging survey of other possible benefits of treatment. This is in line with the opinion of most practising psychiatrists that, though no cure can be offered to complete homosexuals rating Kinsey 6, it is sometimes possible to help bisexual young men gain a more heterosexual outlook. Relief can also be given to some of those homosexuals who are burdened by guilt, neurotic difficulties, or intolerable libidinous tension, and to those who genuinely seek help in restraining overt behaviour likely to involve them in trouble with the law. Future research may clarify these and other indications for medical intervention, but at present the prognosis varies much in different cases.

SPONTANEOUS PNEUMOTHORAX

The real incidence of spontaneous pneumothorax has always been difficult to assess, but N. Wynn Williams[1] has attempted to give a fair answer by analysing all the cases in the Bedford area in the last 10 years. The medical services for a population of 150,000 are centred on Bedford, and in this population 74 cases of spontaneous pneumothorax occurred in 70 patients—an

[7] Olvensky, J., *J. nerv. ment. Dis.*, 1940, **92**, 65.
[8] Myerson, A., *Arch. Neurol. Psychiat. (Chicago)*, 1946, **55**, 291.
[9] Ellis, A., *J. cons. Psychol.*, 1956, **20**, 191.
[10] Allen, C., *Med. Press*, 1956, **235**, 441.
[11] Curran, D., and Parr, D., *Brit. med. J.*, 1957, **1**, 797.
[12] Poe, J. S., *Psychoanal. Rev.*, 1952, **29**, 23.
[13] Freud, A., *Psychoanal. Quart.*, 1951, **20**, 337.
[14] Radzinowicz, L., *Sexual Offences*, 1957, London.
[15] Glover, E., *The Problem of Homosexuality*, 1957.
[16] Liddicoat, R., *Brit. med. J.*, 1957, **2**, 1110.
[17] Parr, D., *Proc. roy. Soc. Med.*, 1957, **50**, 651.
[18] Taylor, F. H., *Brit. med. J.*, 1947, **2**, 525.

average of 5 per 100,000 per annum. Put another way, at this rate approximately 2,500 cases will occur per annum in Great Britain, or the general practitioner with an average list would expect to see one case in 10 years.

The signs and symptoms of the acute attack are well known, but it is worth bearing in mind that 30% have an insidious onset. Most authors have reported a preponderance of males, and the Bedford figures confirm this, the proportion being five to one. But, whereas earlier figures showed that nearly all the patients were under 40, Wynn Williams found over 40% of his patients were over 40. The reason for this was a high incidence of associated chronic pulmonary disease—mainly bronchitis, emphysema, or bronchiectasis, with or without asthma. These patients tolerate badly the increased strain on their already impaired respiration: the 3 deaths in the Bedford series were in this group, as were the 4 deaths out of 61 cases reported by J. S. Crowther.[2] Spontaneous pneumothorax may also occur in association with acute lung infections, especially staphylococcal in children. The relationship of spontaneous pneumothorax with tuberculosis has been much debated. Though for many years it was considered the major cause, the publication of H. Kjaergaard's[3] report in 1932 changed this view. But H. P. Lambert's[4] more recent appraisal two years ago has shown that the relationship is still important. The pneumothorax may be associated with healed lesions, with active lesions, or may precede a radiologically visible tuberculous lesion by a few years.[5] Tuberculosis, being now in decline, will become a less important cause of spontaneous pneumothorax, but the proportion of cases it causes in men over 40 may rise because of the changing age and sex incidence of the disease.

While the aetiological factors and mode of development, well summarized by Brock[6] in 1948, are widely accepted, opinions about treatment have differed. On the whole, treatment has become more active as the thorax is entered with increasing boldness. As a general rule, rest in bed for a week or two is all that is required for a first attack without obvious associated disease. If after two weeks a radiograph shows no sign of re-expansion, then active treatment is justified in all but the mild cases. Active treatment should also be given for recurrences, whether on the same or opposite sides, and for first attacks when there is associated non-tuberculous disease, especially if the patient is over 40 years of age, because of the higher mortality in such cases. After any necessary emergency treatment, an intercostal catheter should be inserted and a suitable sclerosing agent such as iodized talc, silver nitrate, or kaolin introduced. Ideally this is best done with a thoracoscopy cannula, since the surface of the lung can be uniformly sprayed and prior inspection may show the presence of a large bulla, which may be better dealt with by excision at a subsequent thoracotomy. Suction, with careful management of the tube,[2] will quicken the rate of pleural adhesion.[7] Haemopneumothorax occurs in 5–10% of cases and must be regarded as an emergency. Unless bleeding ceases and complete aspiration of blood and re-expansion of the lung are accomplished within a day or two by simple measures, then thoracotomy must be done. The bleeding-point is seldom found, but complete evacuation of blood and rapid re-expansion of the lung will encourage pleural adhesion and usually control the bleeding. Pulmonary function is thus preserved and a future decortication avoided. The excision of large bullae, especially if compression of sound lung tissue is occurring, now has much support both as a curative and a prophylactic measure: even small blebs and bullous areas have been excised. Whatever the method of active treatment, it has one advantage over simple bed rest which may appeal to the patient—he can usually return to work much sooner.

[1] Wynn Williams, N., *Thorax*, 1957, **12**, 253.
[2] Crowther, J. S., *Tubercle* (*Lond.*), 1955, **36**, 265.
[3] Kjaergaard, H., *Acta med. scand.*, 1932, Suppl. 43.
[4] Lambert, H. P., *Tubercle* (*Lond.*), 1956, **37**, 207.
[5] Melrose, A. G., *Glasg. med. J.*, 1950, **31**, 263.
[6] Brock, R., *Thorax*, 1948, **3**, 88.
[7] Maxwell, J., ibid., 1954, **9**, 10.

M.O.H.s' CLAIM REFUSED

It was announced on June 3 that the Industrial Court had refused to establish the claim of the Staff Side of Whitley Committee C for a 5% increase in the salaries of medical officers in the public health service. This decision, particularly disheartening to our public health colleagues, will disturb the whole profession. The claim was based on the rise in the cost of living and the general movement in salaries since public health salaries were last readjusted on April 1, 1956. The court adjudicated against it because "the claimants must be considered as being members of the local authority hierarchy." A separate claim was being considered for other "designated" officers of local authorities—accountants, treasurers, engineers, and so on—and, in the opinion of the court, "it would not be appropriate for the salaries position of public health medical officers to be dealt with piecemeal and in isolation while that general claim is outstanding." Giving evidence last month for the Association of County Medical Officers of Health to the Royal Commission on Doctors' and Dentists' Remuneration, Dr. A. Elliott[1] is reported to have said that until the first award of the Industrial Court doctors in the local government service were dealt with as doctors. He added: "The figures had no regard to what was paid elsewhere in local government." Others giving evidence for the Society of Medical Officers of Health made similar points, Dr. H. D. Chalke saying, "Our basis is that we are first and foremost doctors, and our relationship should be with other doctors." Both the Management Side and the Industrial Court take the opposite view, and there seems to be no possibility of compromise. There is thus now all the greater need for a general review of the salary structure in the public health service. The only crumb of comfort, if it is comfort, that the Industrial Court can offer is to say that its award "is without prejudice to any claim for alteration of the salary structure or otherwise which public health medical officers may decide to put forward when the outstanding claim for designated and other officers has been settled."

[1] *Brit. med. J. Supplement*, May 31, p. 285.
[2] Ibid., May 31, p. 284.