produced a scheme which arbitrarily divided a personal health service into three lopsided divisions with no effective provisions for co-ordination or balanced economy. Certainly, no one whose vision went beyond the narrow confines of politics or the more specialized branches of curative medicine would have forgotten the vital role of preventive medicine. To forget that infectious-diseases hospitals, sanatoria, and, to a considerable extent, maternity hospitals were later adnexa of preventive medicine is on a par with the naive assumption that epidemics have had their day, that tuberculosis is a "general" rather than an infectious disease, and that all that remains of preventive medicine can be reduced to such simple terms as vaccination and immunization.

Having made a case, Sir, for the readjustment of the economy of the service, including the remuneration of those engaged in it, you conclude by saying that payment, or the lack of it, has nothing to do with the present discontent and disillusionment of the profession. Surely that is illogical. Let us face facts, if ever we are to advise the Minister on how best he can spend what money the Treasury will give him. At the present time the allocation of money for health services is roughly in the ratio of 1:12:24 for local health authorities, executive councils, and hospital boards respectively. Hospital administrative costs have shown the most spectacular increases without any increase in the number of available beds. It is almost impossible to obtain an analysis of these costs, but specialists' salaries are known to be a major item, and overhead costs, due to the cumbersome and wasteful system of management by boards, have shocked all who formerly managed the same hospitals.

Having dealt with statistics for more years than I care to remember, I know their limitations, and I am going to suggest that never have there been so many men, especially young men, in receipt of full specialist remuneration. Herein lies, I think, the failure to encourage the budding specialist. Having filled up the establishment there is little chance of succession for many years to come, and it is going to be a very difficult matter to persuade those who have suddenly made the grade that they must forgo some of their remuneration in order to bridge the gap which separates them from their less successful colleagues. The position of the *established* general practitioner, as compared with the entrant to general practice, is somewhat similar. The established doctor in either branch has experienced in the main a definite improvement in his finances as a result of the Act, and we know that the same holds true for dentists and opticians. If the Treasury can spare no more money, then some of this extra remuneration must be applied to the gradual advancement of recruits. I am aware that general practitioners, dentists, etc., are working hard for their money, but I have the impression that the unexpanded hospital service is top-heavy with specialists. Advice is of little use if it cannot be applied in practice—i.e., in hospital. Even in this age of substitution free spectacles or cough mixtures count for little to the chronic sick in their lonely attics, or to the bedridden consumptive awaiting admission to a sanatorium.

Some assume that the clock could be put back where it was on July 5, 1948, but that is manifestly impossible. The vesting date for practices, as well as for hospitals, is as irrevocable as that for the mines. It would appear to be an inevitable, if ironic, conclusion that the only way in which the profession can recast the health services in some semblance of a workable and economic proposition which will improve the health of the people and will, at the same time, attract recruits is to ask the Minister to introduce full State medicine. Those who may recoil, however, from such a suggestion should reflect on just how much they have gained or lost by their insistence on retaining what is little more than a travesty of freedom. We have been saddled with boards and councils whose members in the main know little of medical administration. In order to keep them on the rails they have been issued with directive circulars and supplied with technical officers. Some boards have ignored this guidance, and their management on the whole has not been of a high order. Nevertheless they represent expenditure which could be dispensed with. In a full State service they would disappear and the Minister himself would be directly responsible to Parliament. In their place there would be a small number of higher administrative officers—call them Civil Servants if you will—but the whole service, being highly technical, would inevitably develop on the advice of its technicians. Promotion would be a gradual process determined by the quality and service of the individual. At least we would be spared the unedifying spectacle of laymen being canvassed by prospective general practitioners, of specialists meeting in secret to share out distinction awards, and of the wide anomalies existing between those doing comparable work. The whole artificial and expensive barriers between regions, areas, and branches of the service would likewise disappear, with an improvement in balance and a great saving in man-power and money. There should be sufficient funds left over to provide and staff a number of hospital beds and perhaps one or two experimental health centres. As a realist, can one seriously lay much emphasis on health centres or on the Minister's failure to provide them? Until such time as practitioners pool their patients (an undesirable step) it is unlikely that they will favour communal consulting-rooms.

Finally, I would make a plea that the profession permit those who, by experience and training, have some knowledge of how a full service can be planned to draw up a draft scheme for the future, others having tried and failed.—I am, etc.,

Kirkcaldy. JAMES R. W. HAY.

Pulmonary Complications of Pertussis

SIR,—The annotation on this subject (November 18, p. 1162) states that in an article of mine I did not confirm previous suggestions that the high incidence was related to the severity of the disease. The article referred to contains figures to show that the incidence of pulmonary collapse rises with the severity of the disease.

My series of cases is also referred to as unselected, and it is said that 21% had persistent collapse for more than a year. The series was in fact selected, as all the cases were sufficiently severe to require admission to hospital, and the figure 21% refers to severe cases only.—I am, etc.,

London, S.W.1. DAVID NICHOLSON.

POINTS FROM LETTERS

Psychiatry and the Common Cold

Dr. M. C. ANDREWS (Wembley, Middlesex) writes: Is Dr. H. M. Feldman (November 11, p. 1120) serious when he writes about the emotional cause of the common cold? When I have toothache or a pain in my stomach I suffer from "a decrease of objective feelings of normal affection and sociability, and a tendency to self-absorption, a mood of irritability, and restlessness. . . ." This does not make me think I am suffering from "a basic mental conflict involving some interpersonal relationship." I suspect I have dental caries or have eaten bad food.

Technique of Ventrosuspension

Dr. E. HESKETH ROBERTS (London, W.1) writes: Statistics in gynaecological literature of the results of ventrosuspension by round ligament procedures are insufficient for the guidance of operators; the multiplicity of methods suggests there is scope for improvement, and it has not been emphasized sufficiently that there is a disturbing percentage of sequelae. . . . I found in 1945 that iliac pains were completely avoided by anchoring the plicated or shortened round ligament to the anterior wall of the uterus (utero-teretial suspension), instead of the anterior abdominal wall. . . . But occasional recurrence of retroversion was not prevented until the technique of utero-vesical suspension was added in 1946 . . . a foreshortening of the incised and lifted utero-vesical and para-vesical peritoneum to within 1 cm. of the bladder and stitching it to the upper anterior uterine surface (and laterally beyond the plicated round ligament but in front of the Fallopian tubes, which undergo no distortion). In 1947 I came to the conclusion that this foreshortening with advancement of the peritoneum was the essential portion of the operation to prevent recurrence, but that the utero-teretial plication was probably necessary to ensure sound healing and organization of the utero-vesical peritoneal suture line. After this deduction I substituted 40-day chromic catgut No. 3 for the fascial suture used in the 1946 plication. The relief of tension by plication of the inner two-thirds of the ligamenta teretia enables the use of a continuous suture of No. 1 chromic catgut for the peritoneum, thus diminishing the risk of adhesions due to the free ends of interrupted sutures. In four years I have had no recurrence of retroversion or iliac pains; follow-up is maintained for two years, and it is hoped to give more exact figures later. . . .