

Mr Birnstingl, in seeking to discredit a statement made in the reply to the consultative document that "nearly 75% of consultants and senior registrars favoured the continuance of private practice within the NHS hospitals" by quoting a part of the figures from the relevant questionnaire (7 December 1974, p 608), conveniently ignores the figure on which the approximation of nearly 75% was based. In question 9(a) consultants and senior registrars were asked, "Do you agree in principle with private practice within the National Health Service?" to which the reply "Yes" was given by 73.4% of nearly 10 000 replies. I would submit, therefore, that the statement made in the memorandum of reply (4 October, p 54) that "nearly 75%" favoured the continuance of private practice within NHS hospitals is sound.

Mr Birnstingl goes on to dismiss certain percentage figures relating to the change in the number of pay beds and the size of waiting lists as "statistics which no first-year medical student would accept." That, Sir, is a matter of opinion, but the figures to which I believe he refers were taken from a Government White Paper of 1972 which summarised the findings of a select committee of the House of Commons under Mrs Renee Short's chairmanship which studied the problem of private practice.<sup>1</sup>

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<sup>1</sup> Expenditure Committee, *Fourth Report, Session 1971-2, National Health Service Facilities for Private Patients*. London, HMSO, 1972.

SIR,—At a recent meeting of the junior staff group of this hospital the consultative document on the separation of private practice from National Health Service hospitals was fully discussed. It was unanimously rejected in principle, and the meeting agreed to offer full support in this rejection to you and the Council. Those present also voiced that they were not only men and women of words but also of action.

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#### Consultative document on private practice

SIR,—We the undersigned, being junior medical staff in hospitals in the Thames Health Regions of the south of England, reject the recently published "consultative document" on private practice and the plans contained therein. We believe that it is irrelevant to the real needs of the NHS and can only be divisive at a time when the Secretary of State should be seeking the full co-operation of all the medical profession in maintaining and improving the quality of care at a time of financial stringency. We further believe that this document constitutes a serious attack on the fundamental principle of individual freedom that is the right of every citizen of the United Kingdom.

N D L OLSEN  
and 724 other signatories

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#### Renal transplantation

SIR,—I cannot allow your leading article (11 October, p 66) to pass without comment. As you may know, a recent DHSS circular authorises the senior hospital administrator (lay) on duty, as the person lawfully in possession of the body, to permit the removal of organs for transplantation, even if relations of the deceased are not available to give consent and provided that reasonable efforts have failed to show any evidence of objection by the patient or the family.

Kidneys should be removed within half an hour of death or, preferably, before a respirator is switched off. The relatives of a victim of a catastrophic head injury or subarachnoid haemorrhage may not be immediately traceable. If the senior administrator authorises removal of organs it is quite possible that the family of the donor may be very deeply grieved when they learn that their relation has had organs removed, particularly if they belong to certain religious faiths. In the circumstances, the removal of organs without the clear knowledge or consent of the patient is a gross infringement of human dignity and of human rights. The answer, of course, is clear—a willing donor should carry a card.

As a consultant neurosurgeon I have a responsibility not only to my patient who might be a possible donor but also to his family, and to increase the anxiety or add to the grief of the family is, in my view, intolerable. I shall never permit requests to be made to the relatives either before or after the death of my patients. It is not a matter of preferring to ignore the possibility, as is stated in your leading article.

Anti-transplant propaganda to which you refer may at least in part be attributed to the over-zealous activity of transplant teams who have added to the grief of the families of victims. I have the greatest sympathy with those sufferers who would benefit by renal transplant, but even they must realise that there is a right and a wrong way of procedure in such a delicate matter.

My own correspondence with the DHSS has made it clear that it is not practicable to keep a register either of volunteers or those who do not wish to be donors. Widespread publicity about the availability of donor cards, through all the media, for the benefit of kidney and corneal grafting would go a long way to relieving the prejudice to which you refer, and this would be a morally and ethically justifiable method of obtaining transplant tissue.

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#### Migrainous neuralgia

SIR,—Dr J D Parkes, in his article on the relief of pain (11 October, p 90) under the heading of Migrainous Neuralgia, cites me incorrectly as recommending treatment with dihydroergotamine tartrate 2 mg with promethazine 10-25 mg every evening for six consecutive nights, followed by 24 hours off drugs to see whether spontaneous recovery had occurred. He presumably had in mind my papers on migrainous variants<sup>1</sup> and a particular variety of headache.<sup>2</sup>

These papers were concerned with periodic migrainous neuralgia, first described

by Wilfred Harris, a migrainous variant which, contrary to Dr Parkes's statement, is neither common nor seasonal. It occurs in bouts, usually lasting a few weeks, with intervals of freedom extending from several months to several years. During a bout there are paroxysms of severe pain lasting from half an hour to two hours. There is at least one such attack in 24 hours, usually more. The times of onset of the pain are often fairly constant throughout an individual bout.

I reported the effects not of the treatment mentioned by Dr Parkes but of self-administered intramuscular injections of ergotamine tartrate, the timing and frequency of these being aimed at preventing the paroxysms and the minimum effective dose being determined by trial. In most cases this treatment was successful in preventing the attacks. It was then omitted on one day out of seven and, if during that period there was no attack of pain, it was found almost always that the bout had reached its self-limited end and that the treatment could be stopped.

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<sup>1</sup> Symonds, C P, *Transactions of the Medical Society of London*, 1951, **67**, 337.  
<sup>2</sup> Symonds, C P, *Brain*, 1956, **79**, 217.

#### Medical training in developing countries

SIR,—Surely the British curriculum that Dr B Senewiratne and his colleagues (4 October, p 27) admire is largely a historical relic. Many British medical schools, like those elsewhere, have striven in recent years to make major changes in medical education, recognising the shortcomings of traditional curricula. They have turned outwards towards the community, to primary medical care, prevention and aftercare, and to the concepts of planning medical services and the "health team," as described by Dr J S P Jones (4 October, p 29).

The authors decry the time spent on preventive and social medicine quoting 973 hours in the Colombo curriculum.<sup>1</sup> Detailed study of that curriculum does not disclose to me how this total was reached, since the reality appears to be much less. In Peradeniya the hours allocated to community medicine seem to be about 200. In this time the subjects to be covered include demography, medical sociology, population and family planning, structure and function of health services, nutrition, infectious and parasitic diseases, maternal and child health, housing, sanitation, rural hospital practice, rehabilitation, and industrial health, and so on—many of these are clinical problems and hardly within the competence of the one-year trained public health inspector, as the authors assert.

The claim that tuberculosis presents the same problems in diagnosis and management everywhere is dubious (in Colombo, incidentally, teaching on tuberculosis is one of the responsibilities of preventive medicine). In the UK chest x-ray and sputum culture facilities, a wide range of drugs, and good hospital and community services are all available for the medical onslaught on TB. In a country such as Sri Lanka, where the national health expenditure per head of population is about 1/40th of that in the