ment"—to be appointed by and responsible to Sheffield Regional Hospital Board but having wider powers than ordinary hospital management committees. The new board of management would have 15 members plus a chairman. Six would be nominated by Nottingham University and nine appointed by Sheffield Regional Hospital Board after consultation with local health authorities, executive councils, medical and dental staffs, and other organizations. The chairman would be appointed by the regional board after consultation with the university. On the all-important financial powers of the board of management the report goes on to recommend that it should be empowered to undertake capital works on the same conditions as is a board of governors, and that the Ministry of Health should earmark revenue allocations to the regional board for use by the board of management. Collaboration between the regional hospital board and the new board of management is to be further ensured by the creation of a special co-ordinating committee.

The joint committee's proposals, which have been approved by Nottingham University and Sheffield Regional Hospital Board, go to the Ministry of Health for consideration. They will also be more widely studied for their general interest. Though these are interim measures and are specifically intended for the novel situation at Nottingham, they must be thought relevant to the establishment of other new medical schools—for instance, the one at Southampton.

Monarticular Arthritis in Children

The child with chronic arthritis in a single joint can present a difficult problem in diagnosis. No doubt tuberculosis was once the commonest cause, but tuberculosis of joints is now seen much less frequently in Britain, and a number of other conditions have to be considered. These are rheumatoid arthritis (together with ankylosing spondylitis, psoriatic arthritis, and the arthritis of ulcerative colitis, which when presenting in a single peripheral joint are often indistinguishable from rheumatoid disease); the effects of injury, such as osteochondritis dissecans; and a very small group of rarer miscellaneous disorders, including brucellosis, histoplasmosis, blastomycosis, pigmented villonodular synovitis, synovialoma, haemangioma, and other tumours.

Juvenile rheumatoid arthritis, or Still's disease, usually affects multiple joints, but the onset is sometimes monarticular, and this form of the disease has been described in several recent studies.¹⁻⁹ The proportion of patients with Still's disease starting in a single joint varies in the different series from 10%⁴ to 39%³—no doubt owing to differences in case selection and in diagnostic criteria. Sex and age of onset do not appear to differ from Still's disease as a whole.

The knee is predominantly affected, with the ankle next most commonly; other joints include wrist, hip, elbow, midtarsal, and various joints in the fingers, toes, and cervical vertebrae. In some children the disease remains monarticular, but most eventually progress to a polyarthritis, usually within a year. Remission of disease activity is commoner in those with persistently monarticular disease than in those in whom it becomes polyarticular. Other useful signs of Still's disease, such as the typical fever and rash, are seen only occasionally in these patients. Though iritis is not always found among children with monarticular disease,⁵ it must be looked for carefully, because most reports indicate that it occurs with at least equal frequency to that in polyarticular disease, while in three series^{4, 7, 9} the incidence was higher in the monarticular group.

The main radiographic features consist of local growth abnormalities—longitudinal overgrowth of long bones, enlargement of epiphyseal ossification centres, accelerated epiphyseal maturation, and diminished size of small round bones such as the carpals. Erosion of bone is relatively late and inconspicuous. As with the polyarticular form of Still's disease, serological tests for rheumatoid factor are usually negative and the vascular complications of adult rheumatoid disease are rarely encountered.¹⁰ The appearances of biopsy specimens of synovium vary from a mild synovitis with some hyperplasia of synovial lining cells and minimal round cell infiltration to the classical appearance of rheumatoid synovial membrane with marked hyperplasia, lymphocyte aggregations, plasma cell infiltration, and deposition of fibrin. There is little correlation between the findings at biopsy and the subsequent course of the disease,⁴ but the procedure is of great value in excluding the presence of tuberculosis and other conditions.

There should therefore be no hesitation in carrying out synovial biopsy when—as is usually the case—some doubt exists about the diagnosis. General physical and ophthalmic examination, radiology of joints and chest, tuberculin testing, and microscopic and bacteriological examination of synovial fluid may all help in reaching the answer, but very often results are inconclusive. A needle biopsy nearly always yields adequate tissue for diagnostic purposes and causes none of the discomfort and inconvenience of an open surgical procedure, though the latter has the advantage of permitting direct inspection of the joint and selection of tissue for examination. Whatever the method, early biopsy avoids on the one hand any delay in the diagnosis of tuberculosis and on the other the equally unwarranted mismanagement of Still's disease with antituberculosis chemotherapy and harmful immobilization.

Partnership in Medical Care

Wherever the State and the medical profession come into working contact there seems to be excessive friction. Though in Britain there have been none of the "strikes" that periodically affect doctors in some other countries, relations between the Ministry of Health and the profession have at times been strained and have seldom been cordial. Mr. Kenneth Robinson took up the theme of the relationship between doctors and the State in his Maurice Bloch Lecture to Glasgow University last week, a summary of which is

¹ Sury, B., *Rheumatoid Arthritis in Children*, 1952. Copenhagen.

² Edström, G., *Arthr. and Rheum.*, 1958, 1, 497.

³ Grokoezt, A. W., Snyder, A. I., and Schlaeger, R., *Juvenile Rheumatoid Arthritis*, 1962. Boston.

⁴ Bywaters, E. G. L., and Ansell, B. M., *Ann. rheum. Dis.*, 1965, 24, 116.

⁵ Laaksonen, A. L., *Acta paediat. (Uppsala)*, 1966, Suppl. 166.

⁶ Griffin, P. P., Tachdjian, M. O., and Green, W. T., *J. Amer. med. Ass.*, 1963, 184, 23.

⁷ Brattström, M., and Sundberg, J., *Acta rheum. scand.*, 1965, 11, 266.

⁸ Sundberg, J., and Brattström, M., *ibid.*, 1965, 11, 279.

⁹ Cassidy, J. T., Brody, G. L., and Martel, W., *J. Pediatr.*, 1967, 70, 867.

¹⁰ Bywaters, E. G. L., and Scott, J. T., *J. chron. Dis.*, 1963, 16, 905.

printed at page 675. His subject was partnership in medical care provided under the National Health Service.

Mr. Robinson sees a relationship of mutual confidence between Government and profession as being essential if the N.H.S. is to achieve its full potential. He is puzzled that the efforts of successive Ministers of Health have failed to convince doctors that their suspicions of authority are groundless. He thinks that more doctors, particularly the younger ones, are happier in their environment than their leaders make out, and he notes in the public utterances of the profession's spokesmen a reluctance to give credit to the Government for what it has done and what it has said it intends to do for the Health Service.

There can be some sympathy for Mr. Robinson. He is sincere, and more than most of his predecessors in office he has tried to meet the doctors half way. They, on their part, have been quick to learn the practices of collective bargaining but perhaps slower to discover how to make their authoritative voice heard on matters more directly concerned with the well-being of a profession and of the public which it serves. And, however well intentioned, Mr. Robinson inevitably suffers from any layman's inability fully to understand the finer professional feelings of the doctors with whom he is dealing.

It is a welcome sign that Mr. Robinson has caught the new mood of objective inquiry into the working of the N.H.S. It is to be hoped that his review of its administrative structure will result, as he expects, in reforms that will put the management into proper shape to serve the needs of modern scientific medicine. He also sees the need for an administration that will lead to better co-operation in the functioning of the various branches of the medical services. But whatever changes come about—unless perchance they include a revolutionary decentralization of the responsibility for the provision of medical services—they are unlikely to do much to promote that partnership between the Government and the profession that Mr. Robinson is not alone in thinking to be desirable.

Partnership implies a division of work and a sharing of responsibility among equals. There is no difficulty in differentiating the work of the Minister of Health and his Ministry from that of the doctors. But when Mr. Robinson speaks of partnership does he mean one in which doctors would share equally with him the responsibility for making decisions? It is to be feared that he does not. Indeed, can he share responsibility that is placed on him by statute? The National Health Service multiplied the men in Whitehall and, for better or for worse, made them the masters of the men in the field. That has probably been the greatest single cause of the doctors' discontent, and it is at the root of their mistrust of Government.

Rather than pondering on the irrational behaviour of a seemingly unappreciative lot of doctors or surmising how many younger ones are happier than they are said to be, Mr. Robinson would do well to begin a dispassionate examination of the nature of the discontents that undoubtedly exist. Why do young doctors emigrate? What is there in their new environment which they think will give them the professional satisfaction that they failed to find in the N.H.S.? Why should discontent be if anything more rife among a generation that has never known anything but the N.H.S. than among their older colleagues? The answers to these and other questions might produce some facts which would lead to a better understanding by the Government of the profession's problems, and if not to a true partnership at least to an increase in mutual confidence.

Tetanus Prophylaxis

The treatment which should be given to prevent tetanus in injured patients is still not fully agreed. Each of the prophylactic methods available has drawbacks, and in addition to the difficulties of choosing between them on clinical grounds the doctor must also be concerned that medico-legal complications have an unfortunate association with tetanus and its prevention.

Under ideal circumstances, where the whole community has been actively immunized, there are few difficulties: patients then require only normal surgical toilet of the wounds, together with an injection of tetanus toxoid if more than two or three years have elapsed since a previous booster dose. Such ideal conditions exist in Britain only in the armed Forces and in some industries and institutions. Probably well under half of the general public have been actively immunized, and of these many are unaware of the fact and must often be regarded as non-immune when treated for an injury. Most casualties are thus either non-immune or doubtfully immune, and it is with these patients that the main difficulties of tetanus prophylaxis arise. Almost all of the difficulties would be solved if human tetanus antitoxin could be used; an injection of 250 units provides at least four weeks' protection and is virtually free from side-effects.¹ But only small amounts are available in Britain and at present prophylaxis must be provided by other means.

The first essential of tetanus prevention for all wounds (irrespective of the immune status) is a thorough surgical toilet. A decision must then be made whether further prophylaxis is needed. For fresh, clean wounds in which it is possible to remove completely all foreign matter and dead tissue further measures are not required.²⁻⁴ For wounds not seen until six hours or more after injury, however, 1,500 units of tetanus antitoxin (preceded in the usual way by a small trial dose) should be given, because there is a possibility that a lethal amount of toxin might already have accumulated.^{3, 5}

Patients with more severe wounds will usually require some form of prophylaxis in addition to the surgery, particularly if some doubt remains about the completeness of the toilet. If human antitoxin is not available the practical alternatives are horse serum antitoxin and an antibiotic, and the choice between the two is difficult and controversial. Both undoubtedly can fail; there are many reports of tetanus in patients who had received antitoxin,⁶ and in recent years the disease has been encountered in patients given antibiotic prophylaxis at the time of wounding.^{7, 8} It is not known which fails more often, but the failure rate of either in Britain is presumably very low, because tetanus is extremely rare in injured patients given either antitoxin or antibiotic in casualty departments.^{4, 7} As no properly controlled comparison has been made some grounds other than effectiveness must be used to choose between the two.

¹ *Brit. med. J.*, 1963, 1, 902.

² Parish, H. J., and Cannon, D. A., *Antisera, Toxoids, Vaccines, and Tuberculin in Prophylaxis and Treatment*, 1961, 5th ed. Livingstone, Edinburgh.

³ Laurence, D. R., Evans, D. G., and Smith, J. W. G., *Brit. med. J.*, 1966, 1, 33.

⁴ Sharrard, W. J. W., in *Proceedings of a Symposium on Tetanus in Great Britain*, Leeds, 1967, ed. M. Ellis, p. 137.

⁵ Smith, J. W. G., *Brit. med. J.*, 1964, 2, 1293.

⁶ Bianchi, R., *Helvet. med. Acta*, 1962, 29, 38.

⁷ Ellis, M., *Proc. roy. Soc. Med.*, 1965, 58, 224.

⁸ Lucas, A. O., and Willis, A. J. P., *Brit. med. J.*, 1965, 2, 1333.